



# STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES  
KEVIN W. CONCANNON, DIRECTOR

Representative Henry Waxman  
Chairman, Committee on Oversight and Government Reform  
House of Representatives  
U.S. Congress  
2157 Rayburn House Office Building  
Washington, DC 20515-6143

Dear Chairman Waxman:

Please find enclosed the State of Iowa's response to your request for information dated January 16, 2008. The letter requests Iowa provide an analysis of the impact to the Iowa Medicaid Program, and the supporting documentation for seven regulations proposed or recently finalized by the Centers for Medicare and Medicaid Services (CMS):

1. Cost limits for public providers (CMS 2258-FC)
2. Payment for Graduate Medical Education (CMS 2279-P)
3. Payment for Hospital Outpatient services (CMS 2213-P)
4. Provider Taxes (CMS 2275-P)
5. Coverage of rehabilitative services (CMS 2261-P)
6. Payments for costs of school administrative and transportation services (CMS 2287-P)
7. Targeted Case Management (CMS-2237-IFC).

Please find enclosed in this letter the impact to Iowa for each of the above regulations. Supporting documentation enclosed in Attachments numbered 1 – 9.

## **1. Cost Limits for Public Providers**

The public provider cost limit regulation was published as a final rule by CMS on May 29, 2007. The rule imposes new restrictions on payments to providers operated by units of government and clarifies that those entities involved in the financing of the non-federal share of Medicaid payments must be a unit of government. In addition, the rule formalizes policies for CPEs and other reporting requirements and requires that payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved state plan. Congress enacted a one-year moratorium on the implementation of this rule.

Effective July 1, 2005, Iowa modified the state plan to limit total Medicaid payments for inpatient hospital services, outpatient hospital services and nursing facility services, including graduate medical education payments and any other supplemental payments, to

each public hospital and public nursing facility to no more than the actual medical education and medical assistance costs of each such facility.

These changes were also part of an 1115 Waiver for Iowa, which was approved on July 1, 2005. The Terms and Conditions for the Waiver are enclosed as Attachment 1.

## 2. Graduate Medical Education

The Medicaid program graduate medical education program expenditures regulation published as a proposed rule by CMS on May 23, 2007, provides clarification that costs and payments associated with Graduate Medicaid Education (GME) programs are not expenditures for medical assistance and are not federally reimbursable under the Medicaid program. CMS argues that GME payments are not in compliance with the statute. Congress enacted a one-year moratorium on the implementation of this rule.

Iowa's GME payments, both direct medical education (DME) and indirect medical education (IME), are made to twenty-two (22) hospitals that provide services to Medicaid members. The following table provides a summary of GME payments for State Fiscal Year 2008.

Facility Name	SFY 2008 DME	SFY 2008 IME
The Nebraska Health System	\$ 608,478.14	\$ 589,635.21
St. Luke's Regional Medical Center	\$ 478,847.68	\$ 73,044.12
Trinity Regional Medical Center	\$ 7,204.66	\$ 19,263.57
Iowa Lutheran Hospital	\$ 197,957.94	\$ 194,189.77
Mercy Hospital - Iowa City	\$ 6,017.66	\$ 2,736.19
Genesis Medical Center	\$ 494,073.30	\$ 216,443.03
St. Luke's Methodist Hospital	\$ 187,851.07	\$ 102,332.34
Jennie Edmundson Memorial Hospital	\$ 44,641.24	\$ 11,926.24
University of Iowa Hospitals and Clinics	\$ 6,280,088.79	\$10,908,779.04
Mercy Medical Center - North Iowa	\$ 195,998.95	\$ 213,423.34
Covenant Medical Center	\$ 222,376.87	\$ 110,200.07
Mercy Medical Center - Dubuque	\$ 29,528.53	\$ -
Mercy Medical Center - Cedar Rapids	\$ 99,274.51	\$ 24,035.67
Iowa Methodist Medical Center	\$ 566,343.51	\$ 901,897.02
Mercy Medical Center - Des Moines	\$ 411,749.77	\$ 502,747.58
Broadlawns Medical Center	\$ 855,189.33	\$ 406,250.55
Allen Memorial Hospital	\$ 116,511.06	\$ 60,469.41
Trinity at Terrace Park	\$ 73,648.07	\$ 22,497.29
Mercy Medical Center - Sioux City	\$ 155,490.49	\$ 45,947.83
Alegent Health - Immanuel Medical Center	\$ 8,117.83	\$ 5,597.88
Children's Hospital	\$ 24,977.82	\$ 193,205.94
Creighton University Hospital	\$ 385,703.81	\$ 419,239.91
<b>Total</b>	<b>\$11,450,071.00</b>	<b>\$15,023,862.00</b>

It is difficult to estimate the total impact on the State of Iowa due to the ambiguity of the proposed rules. On June 21, 2007, the Iowa Department of Human Services, Iowa Medicaid Enterprise, submitted comments regarding CMS' proposed rule. A copy of this letter has been enclosed (Attachment 2). It appears that the proposed rule eliminates payments for direct medical education only and continues to allow states to provide payment for indirect medical education costs. However, it is not clear how CMS is defining both direct and indirect medical education nor is it clear as to what medical education costs are to be considered as non-allowable Medicaid costs.

Iowa has estimated that the reduction in federal Medicaid medical education funds will be within the range of \$7.1 million to \$16.5 million annually based on eliminating only the DME payments or eliminating both DME and IME payments.

### **3. Hospital Outpatient Services**

The Medicaid program clarification of outpatient clinic and hospital facility services definition and upper payment limit regulation published as a proposed rule by CMS on September 28, 2007, amends the regulatory definition of outpatient hospital services for the Medicaid program and implements a restriction for upper payment limit methodologies for private outpatient hospitals and clinics. This regulation has no impact on the State of Iowa and there is no reduction in federal Medicaid funds expected over the next five years.

### **4. Provider Taxes**

The provider tax regulation published as a proposed rule by CMS on March 23, 2007, seeks to clarify a number of issues in the original regulation, including more stringent language in applying the hold-harmless test. The new language also affords CMS broader flexibility in identifying relationship between provider taxes and payment amounts. The proposed rule also implements P.L. 109-432 Tax Relief and Health Care Act which codifies that the maximum amount that a state may receive from a health care-related tax is six (6) percent. It also temporarily reduces the permissible rate from January 1, 2008 through 2011 to 5.5 percent. On October 1, 2011, the cap would revert back to six (6) percent pending further Congressional action.

Currently, Iowa assesses a provider tax on patient revenues of all intermediate care facilities for the mentally retarded (ICF/MR). Prior to January 1, 2008, the tax rate was six percent of revenue. Pursuant to Iowa's 1115 Waiver Terms and Conditions (see Attachment 1), Iowa agreed it would not implement any new provider taxes after July 1, 2005.

As of January 1, 2008, the tax rate was changed to 5.5 percent of total revenue to comply with P.L. 109-432. It is estimated the reduction in federal Medicaid funds is \$967,300 in State Fiscal Year 2009.

### **5. Rehabilitative Services**

The rehabilitative services regulation (CMS 2261-P) clarifies the definition of rehabilitation covered under the Medicaid Program. In the past, Iowa Medicaid provided coverage for rehabilitative services under two programs, Rehabilitative Treatment Services (RTS) and

Adult Rehabilitation Option (ARO). In 2006 we redesigned the way rehabilitative services are provided in Iowa, approved under State Plan Amendment MS-07-001, effective January 1, 2007. The RTS program, which is now known as Remedial Services, was redesigned to function under a medical model. These rehabilitative services utilize a treatment plan ordered by a Licensed Practitioner of the Healing Arts, and must be preauthorized by Iowa Medicaid. Concurrently with that change, the ARO program was discontinued and was replaced by the nation's first State Plan HCBS program as allowed under section 1915(i) of the Social Security Act approved effective January 1, 2007. These changes allowed Iowa to serve more Medicaid recipients with a wider variety of services.

Iowa implemented these changes prior to publication of the CMS regulations on rehabilitative services, and as such, the regulations will not impact Iowa either fiscally, or in terms of availability of services. Enclosed is a copy of Iowa's response to the National Association of State Medicaid Director's survey of the impact of the regulation on Iowa (Attachment 3), a copy of the rules for our remedial services program (Attachment 4), and a copy of Iowa's 1915(i) waiver (Attachment 5).

## **6. School Administrative and Transportation Services**

The rule related to payments for costs of school administrative and transportation services (CMS 2287-P) was finalized on December 28, 2007, with an effective date of June 28, 2008. In State Fiscal Year 2006, expenditures totaled \$27,000 for school based administrative services in the Iowa Medicaid Program. Iowa terminated the program in June 2007 as the cost of oversight of the program exceeded the benefit realized from the program. Enclosed are copies of letters sent from the Iowa Medicaid Program to participating school districts discontinuing the program (Attachment 6).

There will be a fiscal impact on school districts due to the loss of Medicaid reimbursement for the change to transportation services. The estimated loss is \$1,301,760 in federal financial participation for participating school districts in Iowa.

## **7. Targeted Case Management**

Iowa has reviewed the CMS interim final rule on targeted case management (CMS-2237-IFC) and how it would impact Iowa's Medicaid targeted case management program. Three documents were created as a result of the review and are enclosed.

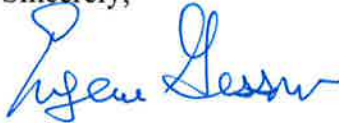
- Attachment 7 – "State Analysis of CMS Interim Final Rule" breaks out all the sections of the regulation and the related guidance from CMS, and then notes Iowa's current practice and policy for case management, and changes that would be required by the new regulations.
- Attachment 8 – "Target Groups" examines the new regulations by each demographic group that is currently receiving case management in Iowa. This provided the state with two perspectives on these regulations and an assessment of the issues that need to be addressed in implementation.
- Attachment 9 – "Questions on Centers for Medicare and Medicaid Interim Final Rule" was created following the other two documents. This document lists the questions for which

Iowa needed clarification. The document was utilized during a joint meeting with Iowa staff, regional CMS staff, and CMS central office staff to discuss the issues and questions Iowa identified.

These rules will likely have a cost to implement for the Medicaid program and providers. A detailed fiscal analysis has not been performed. The cost to the state is expected to be less than \$2 million. The state is in the process of moving forward with implementation.

Please contact Jennifer Vermeer, Assistant Medicaid Director at 515-725-1144 if you have questions or require further information.

Sincerely,

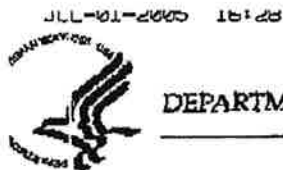
A handwritten signature in blue ink, appearing to read "Eugene Gessow". The signature is fluid and cursive, with a large initial "E" and "G".

Eugene I. Gessow  
Medicaid Director

**State of Iowa**

**Request for Information Response to  
Representative Henry Waxman**

**February 15, 2008**



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Centers for Medicare &amp; Medicaid Services

Administrator  
Washington, DC 20201

JUL -1 2005

Mr. Kevin Concannon  
Director  
Iowa Department of Human Services  
1305 E. Walnut Street  
Des Moines, IA 50319-0114

Dear Mr. Concannon:

We are pleased to inform you that the Iowa section 1115 Medicaid demonstration project, entitled IowaCare (Project No. 11-W-00189/7) has been approved for a 5 year period, from July 1, 2005, through June 30, 2010, in accordance with section 1115(a) of the Social Security Act (the Act).

Our approval of the IowaCare 1115(a) demonstration project, including the expenditure authorities provided thereunder, are conditioned upon compliance with the enclosed Special Terms and Conditions (STCs). The STCs set forth in detail the nature, character, and the extent of Federal involvement in the demonstration. The STCs are effective July 1, 2005, unless otherwise specified. All the requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed expenditure authority list, shall apply to the IowaCare demonstration.

The Department of Health and Human Services' approval of IowaCare, including the associated expenditure authorities, is contingent upon compliance with the enclosed list of STCs.

The following list summarizes the negotiated components of the demonstration project.

Expansion Population

Iowa will provide a limited set of Medicaid benefits to adults ages 19 through 64, including parents of Medicaid and SCHIP-eligible children, using a provider network at the University of Iowa Hospitals and Broadlawns Hospital. Enrollees will be required to pay monthly premiums not to exceed 5 percent of annual family income.

Home and Community-Based Waiver for Seriously Emotionally Disabled Children

Iowa will incorporate home and community-based services for children diagnosed with chronic mental illness. These children will receive full Medicaid State plan services as well as supportive services in the community. This will enable children who would otherwise be served in inpatient facilities to remain with their families in the community. Although authority is granted under section 1115(a), this program will operate using the principles of home and community-based waivers.

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Payment Reform

Iowa will cease the financing arrangements which inappropriately obtain Federal financial participation (FFP) for its Medicaid State plan and agrees not to implement any new provider taxes for the duration of the demonstration.

Mental Health Transformation Pilot

The FFP will be permitted in a limited amount for services rendered through the Mental Health Transformation Pilot. This expenditure authority is granted only as a "stop gap" measure to maintain current Federal funding levels to ensure proper care to the State's vulnerable populations. We expect that prior to applying for a renewal of this waiver, the State will have planned alternatives to this funding approach.

Budget Neutrality

The demonstration is approved with an aggregate budget neutrality limit of \$587.7 million total computable for the 5 years of the demonstration. The management of your program within the approved budget cap is essential in order to successfully meet the terms of budget neutrality for the demonstration project.

Implementation Plan

Iowa will be required to provide an Implementation Plan to implement the provisions of this waiver.

Evaluation

Iowa will be required to conduct an evaluation of the impact of all facets of the demonstration program during the approval period.

A full listing of the approved expenditure authorities for the demonstration is enclosed.

We commend the State for your interest in providing long-term care services consistent with the President's New Freedom Initiative and in support of the Olmstead ruling. We are committed to working with you on State plan amendment 05-012, with a requested effective date of July 1, 2005. Our mutual goal is to design and implement a program that will improve the management of and access to community services in a manner that will ensure beneficiaries' access to high quality and cost-effective care.

Written notification to our office of your acceptance of this award must be received within 30 days after you receive this letter. Your project officer is Mr. Stephen Hrybyk. He is available to answer any questions concerning this demonstration project. Mr. Hrybyk's contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and State Operations  
Mailstop S2-01-06  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Telephone: (410) 786-1058  
Facsimile: (410) 786-5882  
E-mail: Stephen.Hrybyk@cms.hhs.gov

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Official communications regarding program matters should be sent simultaneously to Mr. Hrybyk and to Mr. James Scott, Associate Regional Administrator for the Division of Medicaid and Children's Health in our Kansas City Regional Office. Mr. Scott's address is:

Center for Medicare & Medicaid Services  
Division of Medicaid & Children's Health  
Richard Bolling Federal Building  
Room 235  
601 East 12th Street  
Kansas City, MO 64106

If you have questions regarding this approval, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at 410-786-5647.

Again, congratulations on the approval of your section 1115 demonstration. We are also enclosing your HCFA-179, at your request. We look forward to continuing to work with you and your staff.

Sincerely,



Mark B. McClellan, M.D., Ph.D.

Enclosures

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### **Expenditure Authorities for Iowa's IowaCare Demonstration**

#### **Medicaid Costs Not Otherwise Matchable**

Under the authority of section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this demonstration, be regarded as expenditures under the State's Title XIX Plan. All requirements of the Medicaid statute shall be applicable to such expenditures, except those specified below as not applicable to these expenditure authorities. In addition, all requirements in the enclosed Special Terms and Conditions will apply to these expenditure authorities.

1. **Demonstration Population 1:** Expenditures for services provided to:
  - Individuals ages 19 through 64 with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL) who do not meet eligibility requirements of the Medicaid State Plan or any other waiver except the Family Planning waiver under Title XIX; and
  - Parents whose incomes between 0 and 200 percent of the FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, who are not otherwise Medicaid eligible.
2. **Demonstration Population 2:** Expenditures for obstetrical and newborn care provided to newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses of all family members that reduce available family income to 200 percent of the FPL.
3. **Demonstration Population 3:** Expenditures for services provided to children from birth to age 18 who have serious emotional disabilities and who:
  - Would be eligible for State Plan services if they were in a medical institution; and
  - Need home and community-based services in order to remain in the community;

And who:

  - Have income at or below 300 percent of the SSI Federal benefit; or
  - Have net family income at or below 250 percent of the FPL for family size.
4. **Demonstration Expanded Services 1:** Expenditures for services not otherwise covered under the Medicaid State plan that are comparable to the services provided to Demonstration Population 1, and are provided to individuals in eligibility groups receiving only limited benefits under the Medicaid State plan.
5. **Demonstration Expanded Services 2:** Expenditures for care and services furnished by or through the Department of Human Services under the Mental Health Transformation Pilot

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that would not otherwise be covered under Title XIX or this demonstration will be capped at the following amounts for each year of the demonstration.

DY	Annual Limit on Expenditures for Demonstration Expanded Services 2
FFY 2006	\$26 million
FFY 2007	\$26 million
FFY 2008	\$26 million
FFY 2009	\$9 million
FFY 2010	\$0

#### **Exceptions to Medicaid Requirements for Demonstration Populations & Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement shall apply to the demonstration populations and services except for the following:

##### **Methods of Administration: Transportation**

1902(a)(4) and 42 CFR 431.50

The State is not required to assure transportation to and from providers for Demonstration Populations 1 and 2.

##### **Eligibility Procedures**

1902(a)(10)(A) and  
1902(a)(10)(C)(I)-(III)

The State may use streamlined eligibility procedures for Demonstration Populations 1 and 2.

##### **Redetermination**

1902(a)(19) and 42 CFR 435.930(b)

The State is not required to send notice of renewal of enrollment in IowaCare to beneficiaries at the end of twelve months.

##### **Comparability**

1902(a)(10)(B)

The State may offer different benefits to Demonstration Populations.

##### **Cost-sharing and Premiums**

1902(a)(14)

The State may charge premiums for Demonstration Populations 1 and 2.

##### **Financial Responsibility/Deeming**

1902(a)(17)(D)

The State may consider the income of family members other than a spouse or parent in determining eligibility for Demonstration Populations 1 and 2.

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Freedom of Choice

1902(a)(23)

The State may limit freedom of choice of provider for Demonstration Populations 1 and 2.

Retroactive Eligibility

1902(a)(34)

The State is not required to provide services to Demonstration Populations 1 and 2 for any time prior to when an application for IowaCare is made.

Early and Periodic Screening, Diagnostic,  
and Treatment Services

1902(a)(43)

The State is not required to provide coverage of early and periodic screening, diagnostic, and treatment services to 19 and 20 year-old members of Demonstration Populations 1 and 2.

Income & Eligibility Verification

1902(a)(46)

The State may accept self-attestation as proof of income for IowaCare eligibility determinations for Demonstration Populations 1 and 2.

Disenrollment for Non-Payment of Premiums

1916(e)(3)

The State may disenroll individuals in Demonstration Populations 1 and 2 after providing notice of such disenrollment for failure to pay premiums without requiring the failure to continue for sixty days. Beneficiaries will have access to a fair hearing process to appeal the disenrollment.

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**CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL TERMS AND CONDITIONS**

**NUMBER:** 11-W-00189/7  
**TITLE:** IowaCare Section 1115 Demonstration  
**AWARDEE:** Iowa Department of Human Services

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for Iowa's IowaCare section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Iowa Department of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). This Demonstration is approved for the five-year period, from July 1, 2005 through June 30, 2010. The special terms and conditions set forth below and the list of expenditure authorities are incorporated in their entirety into the letter approving the Demonstration.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; General Financial Requirements; Monitoring Budget Neutrality; Medicaid Reimbursement and Finance; Operational Issues; and Evaluation.

**II. GENERAL PROGRAM REQUIREMENTS**

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, & Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.
3. **Changes in Law.** The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this Demonstration.
4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such

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changes into a modified budget neutrality expenditure cap for the Demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall be required to submit Title XIX State plan amendments for reimbursement methodologies affecting any populations covered solely through the Demonstration. However, the State shall not be required to submit Title XIX State plan amendments for benefits and eligibility changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, Federal financial participation, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The state shall not implement changes to these elements without prior approval by CMS. CMS and the State shall develop a comprehensive list within 60 days of the approval of the Demonstration renewal that shall contain all elements of the Demonstration that are subject to the amendment process. Amendments to the Demonstration shall not apply before the effective date.
7. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 90 days prior to the date of implementation. Amendment requests as specified above shall include the following:
  - a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
  - b) A current assessment of the impact the requested amendment shall have on budget neutrality;
  - c) An explanation of how the amendment is consistent with the overall principles and objectives of the Demonstration;
  - d) A description of how the evaluation design shall be modified to incorporate this amendment request.
8. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase-out the Demonstration, the State shall submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline

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shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant costs not otherwise matchable are suspended by the State, CMS shall be liable for only normal close-out costs.

9. **Enrollment Limitation.** During the last six months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current State plan shall not be permitted unless the Demonstration is extended by CMS.
10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
11. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs.
12. **Adequacy of Infrastructure.** The State shall insure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other Demonstration components.
13. **Public Notice and Consultation with Interested Parties.** The State shall comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) when any program changes to the Demonstration, including, but not limited to, those referenced Section II, paragraph 6 and Section IX are proposed by the State.
14. **Federal Funds Participation.** No Federal matching for expenditures for this Demonstration will take effect until the implementation date.

### III. GENERAL REPORTING REQUIREMENTS

15. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to health care delivery, enrollment, quality of care, access, the benefit package, cost-sharing, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

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**16. Quarterly Reports.** The State shall submit progress reports 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include:

- a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package and other operational issues.
- b) Action plans for addressing any policy and administrative issues identified.
- c) Enrollment data including the number of persons in each Demonstration Population served under the waiver.
- d) Budget neutrality monitoring tables.
- e) Progress on the IowaCare implementation plan.
- f) Other items as requested.

**17. Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

**18. Annual Program Compliance Evaluation.** The State shall submit an annual evaluation documenting Iowa medical assistance program compliance with each of the following:

- That the state has not instituted any new provider taxes governed by 1903(w) of the Social Security Act (hereinafter "the Act").
- That providers retain 100 percent of the total computable payment of expenditures claimed under Title XIX of the Act.
- That government-operated hospitals and nursing facilities are not paid more than the actual costs of care for medical care and medical education based upon relevant Medicaid statutory and regulatory provisions as well as the approved Medicaid State plan.
- That expenditures claimed under Title XIX of the Act for the Mental Health Transformation Pilot are expended for Demonstration Expanded Services 2 (as defined in item 4.b. of Attachment A).

#### **IV. ELIGIBILITY, ENROLLMENT AND BENEFITS**

**19. Demonstration Populations.** The following populations are included in the Demonstration:

- a) **Demonstration Population 1 (Expansion Population)** includes the following:
  - i) Individuals ages 19 through 64 with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL) who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under Title XIX; and
  - ii) Parents whose incomes between 0 and 200 percent of the FPL is considered in

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determining the eligibility of a child found eligible under either Title XIX or Title XXI, and who are not otherwise Medicaid eligible.

- b) **Demonstration Population 2 (Spend-Down Pregnant Women)** includes newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses for all family members that reduce available family income to 200 percent of the FPL.
- c) **Demonstration Population 3 (Seriously Emotionally Disabled Children)** includes children from birth to age 18 who have serious emotional disorders and:
- Would be eligible for State Plan services if they were in a medical institution; and
  - Who need home and community-based services in order to remain in the community;
- And who:
- Have income at or below 300 percent of the SSI Federal benefit; or
  - Have net family income at or below 250 percent of the FPL for family size.

Children who are being served on June 30, 2005 through the State foster care system and meet the eligibility criteria shall be given first priority for enrollment in the Demonstration.

20. **Enrollment Cap.** The State reserves the right to limit the Demonstration Population 1 and 2 to those who are first to apply. However, any limitation for these populations must be submitted to CMS for review and approval following the process outlined in Special Term and Condition 6.

21. **Benefits and Coverage for Demonstration Populations 1 and 2.** The benefits and coverage for these populations shall be limited to inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, dental, pharmacy, medical equipment and supplies and transportation services to the extent that these services are covered by the Medicaid State plan. All conditions of service provision will apply in the same manner as under the Medicaid State plan including, but not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be medically necessary.

22. **Benefits and Coverage for Demonstration Population 3.** In addition to all the benefits offered under the Medicaid State plan, the individuals in Demonstration Population 3 shall be eligible for the following benefits:

a) **Case Management.** Services that will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case management services may not include the administration of the State's foster care program. Case managers must meet the State's provider qualifications and may include any willing provider.

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**b) Respite Care.** Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Services will be provided in the following settings: Individual's home or place of residence; Foster home; Medicaid certified hospital; Medicaid certified NF; Medicaid certified ICF/MR; Group home; Adult Day Care Center; Assisted Living; Camp; or Child Care Facility.

**c) Environmental Modifications and Adaptive Devices.** Items installed or utilized within the child's home that respond to specific documented health and safety concerns. Items may include, but are not limited to, smoke alarms, window/door alarms, pager supports and fencing.

**d) In Home Family Therapy.** Skilled therapeutic services provided to the child and the family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and their familial relationships. The service will support the family by the development of coping strategies that will enable the child to continue living within the family environment.

**e) Family and Community Support Services.** This service shall be provided under the recommendation and direction of the mental health professionals that are included in the child's interdisciplinary team. These professionals in conjunction with the other members of the interdisciplinary team shall mutually identify interventions that will assist the child and family in the development of skills related to stress reduction, management of depression, and psychosocial isolation.

The service provider shall incorporate the mutually identified interventions into the service components that may include the following:

- i) Development of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management and maintenance of the home environment);
- ii) Development of positive socialization and citizenship skills in the community while engaging in community activities; and
- iii) Development of a crisis support network.

The Family and Community Support Services service may include an amount not to exceed \$1,500.00 annually per child for Individual Support Needs, which may include the following:

- i) Transportation within the community excluding medical transportation which is included under the State Plan; and
- ii) Therapeutic resources that may include books, training packages, and visual or audio media as recommended by the interdisciplinary mental health professionals. The therapeutic resources are the property of the child and/or family.

The hierarchy for payment of Individual Support Needs is as follows:

- i) The child's family or legal representative
- ii) Community resources

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- iii) Durable Medical Equipment or Supplies (Medicaid State Plan)
- iv) Individual Support Needs

The following are specifically excluded from Medicaid payment for In Home Family Therapy and Family and Community Support Services:

- i) Vocational Services
- ii) Prevocational Services
- iii) Supported Employment Services, and
- iv) Room and board

Benefits and coverage provided to Demonstration Population 3 will be operated under the principles of a home and community-based services waiver.

## V. COST SHARING

23. Premiums may be charged to individuals in Demonstration Populations 1 and 2 as follows:

Population	Premiums
<ul style="list-style-type: none"> <li>• Individuals ages 19 through 64 with family incomes between 0 and 100 percent of FPL who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under Title XIX;</li> <li>• Parents whose incomes between 0 and 100 percent of FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, and who are not otherwise Medicaid eligible.</li> </ul>	No more than one-twelfth of two percent of the individual's annual family income
<ul style="list-style-type: none"> <li>• Individuals ages 19 through 64 with family incomes between 100 and 200 percent of FPL who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under Title XIX;</li> <li>• Parents whose incomes between 100 and 200 percent of FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, and who are not otherwise Medicaid eligible.</li> </ul>	No more than one-twelfth of five percent of the individual's annual family income

## VI. DELIVERY SYSTEMS

24. **Provider Network.** The provider network serving Demonstration Populations 1 and 2 includes government-operated acute care teaching hospitals and the University of Iowa Hospitals and Clinics.

Demonstration Population 2 may also receive obstetric and newborn services from any Medicaid-certified provider, unless the beneficiary resides in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington counties, in which case the beneficiary must receive obstetric and newborn services from the University of Iowa

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### Hospitals and Clinics.

Demonstration Population 3 may use all Medicaid-certified providers rendering the services outlined in Attachment D.

## VII. GENERAL FINANCIAL REQUIREMENTS

25. The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Attachment B (Monitoring Budget Neutrality for the Demonstration).
26. The following describes the reporting of expenditures subject to the budget neutrality cap:
  - a) In order to track expenditures under this Demonstration, Iowa shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered). Corrections for any incorrectly reported Demonstration expenditures for previous Demonstration years must be input within three months of the beginning of the Demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2c.
  - b) For each Demonstration year, Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures subject to the budget neutrality cap. The State must complete separate forms for each Demonstration Population: 1) Expansion Population 2) Spend-down Pregnant Women, and 3) Seriously Emotionally Disabled Children. The forms for each Demonstration Population must reflect expenditures net of Demonstration Expansion Services. The sum of the quarterly expenditures for the three population categories and Demonstration Expansion Services for all Demonstration years shall represent the expenditures subject to the budget neutrality cap (as defined in item 2.c.).
  - c) For purposes of this section, the term "expenditures subject to the budget neutrality

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cap" shall include all expenditures on behalf of the individuals included in the Demonstration Populations (as described in item 3 of this section), as well as Demonstration Expansion Services (as described in item 4 of this section). All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and shall be reported on Forms CMS-64.9Waiver and/or 64.9P Waiver.

- d) Premiums and other applicable cost sharing contributions from enrollees collected by the State from enrollees in Demonstration Populations 1 and 2 shall be reported to CMS on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, the IowaCare premium collection should be separated from other collections in the Iowa Medicaid program and reported in the memo portion of the CMS report as well as reported on line 9.D of the CMS-64 Summary Sheet.
- e) Administrative costs shall not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
- f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the Demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

27. For the purposes of this Demonstration, the term "Demonstration eligibles" refers to the following three categories of enrollees:

- a) **Expansion Population.** (Demonstration Population 1)
  - (i) Individuals ages 19 through 64 with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL) who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under Title XIX; and
  - (ii) Parents whose incomes between 0 and 200 percent of the FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, and who are not otherwise Medicaid eligible.
- b) **Spend-down Pregnant Women.** (Demonstration Population 2) Newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses of all family members that reduce available family income to 200 percent of the FPL.

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- c) **Seriously Emotionally Disabled Children.** (Demonstration Population 3) Children from birth to age 18 who have serious emotional disabilities and who:
- Would be eligible for State Plan services if they were in a medical institution; and
  - Who need home and community-based services in order to remain in the community;
- And who:
- Have income at or below 300 percent of the SSI Federal benefit; or
  - Have net family income at or below 250 percent of the FPL for family size.

28. For the purposes of this Demonstration, the term "Demonstration expansion services" refers to:

- a) **Demonstration Expanded Services 1:** Expenditures for services not otherwise covered under the Medicaid State plan provided to individuals in eligibility groups receiving only limited benefits under the Medicaid State plan.
- b) **Demonstration Expanded Services 2:** Expenditures for care and services furnished by or through the Department of Human Services under the Mental Health Transformation Pilot that would not otherwise be covered under Title XIX or this Demonstration.

29. The standard Medicaid funding process shall be used during the Demonstration. Iowa must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

30. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Attachment B:

- a) Administrative costs, including those associated with the administration of the Demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan;
- c) Net medical assistance expenditures made with dates of service during the operation of the Demonstration.

31. The State shall certify State/local monies used as matching funds for the Demonstration

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and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

32. The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

#### **VIII. MONITORING BUDGET NEUTRALITY**

33. Iowa shall be subject to a cap on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period.
34. Budget neutrality is determined on an aggregate cap basis as follows:
- a) For each year of the budget neutrality agreement an annual cap is calculated for the entire Demonstration.
  - b) The annual limit for the base year (FFY 2006) is \$102.2 million.
  - c) Years 2 -5 of the demonstration period have an annual cap determined by applying a trend rate of 7% to the previous year's cap.
  - d) The budget neutrality cap for the Demonstration is the sum of the annual caps for the demonstration period:

<b>Demonstration Year</b>	<b>Annual Budget Neutrality Cap</b>
FFY 2006	\$102.2 million
FFY 2007	\$109.4 million
FFY 2008	\$117.0 million
FFY 2009	\$125.2 million
FFY 2010	\$134.0 million
<b>Cumulative Total</b>	<b>\$587.7 million</b>

- e) Notwithstanding item d above, the budget neutrality cap for the Demonstration may be increased to accommodate caseload growth for Demonstration Population 3. Should caseload exceeds 300 person-year participants in Demonstration Population 3 during any year of the Demonstration, the annual budget neutrality cap for that year will be increased to make an allowance for caseload growth if the cost of the Demonstration appears to be exceeding budget targets. Retrospective adjustment will be considered for up to seven years after implementation of the Demonstration (up to

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two years following the five year demonstration project period).

- i) The increase in the annual budget neutrality cap shall be calculated as a product of the number of children enrolled in *Demonstration Population 3* which exceeds 300, times the per member per year (PMPY) cost of providing services to *Demonstration Population 3*.
  - ii) The PMPY costs are determined by applying trend rate of 7.0 percent to the SFY 2006 cost of services provided to *Demonstration Population 3* (estimated to be \$30,658.04 per year for SFY 2006 in Iowa's HCBS application).
35. The Federal share of this limit shall represent the maximum amount of FFP that the State may receive during the approved demonstration period for the IowaCare program. For each DY, the Federal share shall be calculated using the Federal medical assistance percentage (FMAP) rate(s) applicable to that year.
36. Expenditures for *Demonstration Expanded Services 2* shall be capped at the following amounts for each year of the Demonstration:

DY	Annual Limit on Expenditures for <i>Demonstration Expanded Services 2</i>
FFY 2006	\$26 million
FFY 2007	\$26 million
FFY 2008	\$26 million
FFY 2009	\$9 million
FFY 2010	\$0

37. The expenditure limits outlined in item 4 above will not apply to *Demonstration Expanded Services 2* if the Mental Health Transformation Pilot is successful in moving these services from institutional settings to non-institutional settings and/or under the management of a Prepaid Inpatient Health Plan. This determination shall be made each year, based on the IowaCare implementation plan updates required by Section X.
- a) In FFY 2009, the \$17 million reduction in the expenditure limit may only be expended for non-institutional services or PIHP payments.
  - b) In FFY 2010, the \$26 million reduction in expenditure limits may only be expended for non-institutional services or PIHP payments.
38. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the Demonstration years, the State shall submit a corrective action plan to CMS for approval.

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<u>Year</u>	<u>Cumulative Target</u> (Total Computable Funds)	<u>Cumulative Target Definition</u>	<u>Percentage</u>
1	\$103.2 million	Year 1 budget neutrality cap plus	1 percent
2	\$212.6 million	Years 1 and 2 combined budget neutrality caps plus	0.5 percent
3	\$328.6 million	Years 1 through 3 combined budget neutrality caps plus	0 percent
4	\$453.8 million	Years 1 through 4 combined budget neutrality caps plus	0 percent
5	\$587.7 million	Years 1 through 5 combined budget neutrality caps plus	0 percent

The State shall subsequently implement the approved corrective action plan.

39. If at the end of this Demonstration period the budget neutrality limit has been exceeded, the State assures CMS that the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.
40. After December 31, 2005, no duplication of coverage of the Part D benefits shall be provided under this Demonstration.

#### **IX. MEDICAID REIMBURSEMENT AND FINANCE**

41. The State will not finance the non-federal share through the imposition of any new health care provider taxes during the period of the demonstration including, without limitation, taxes on hospitals, nursing facilities, physicians or pharmacies. (Note: changes in federal law related to health care related taxes will be applicable to the existing Iowa ICF/MR tax.)
- a) By July 1, 2005, the State shall formally withdraw pending State Plan Amendment (SPA) 03-24, submitted to CMS on December 12, 2003 with a proposed effective date of October 1, 2003. This SPA proposed to increase reimbursement to nursing facilities (NFs) based on collection of a proposed variable rate NF service tax.
42. The State shall submit or, if applicable, resubmit formal SPAs in accordance with Section 1915 (f) of the Social Security Act as interpreted by 42 CFR 430.10 as follows:
- a) The State shall resubmit responses to CMS request for additional information related to pending SPAs 03-012, 03-023, and 04-013 with revised state plan language terminating inpatient UPL supplemental payments, supplemental disproportionate share payments, supplemental graduate medical education payments, and nursing facility UPL supplemental payments in which providers qualifying for said payments do not retain the total computable amount claimed by the state. The payment methodologies authorizing each of the above referenced payments must be terminated

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by June 30, 2005.

- i) SPA 03-012 modifies several factors used in setting regular inpatient hospital payment rates, which in turn would affect existing supplemental inpatient payments that are returned to the State by state and non-state government hospitals.
  - ii) SPA 03-023 modifies several factors used in setting regular nursing facility payment rates, which in turn would affect existing supplemental NF payments that are returned to the State by non-state government nursing facilities.
  - iii) SPA 04-013 modifies several factors used in setting regular nursing facility payment rates, which in turn would affect existing supplemental NF payments that are returned to the State by non-state government nursing facilities.
- b) The State shall submit new SPAs effective July 1, 2005 limiting total Medicaid payments for inpatient hospital services, outpatient hospital services and nursing facility services, including graduate medical education payments, and any other supplemental payments, to each Iowa government-operated hospital and each Iowa government-operated nursing facility to no more than the actual medical education and medical assistance costs of each such facility as reported on the Medicare 2552 hospital and health care complex cost report (CMS Form-2552) submitted to the CMS and shall be funded consistent with federal statute and regulations. Disproportionate share hospital payments will be limited to the State's DSH allotment and applicable hospital-specific DSH limits and shall be funded consistent with federal statute and regulations.
43. Further, the State shall resubmit SPA 04-007 limiting payment for the high cost adjustment payments for state owned hospitals with over 500 beds to the time period of July 1, 2004 through June 30, 2005. This SPA provides in part for a payment to be added on to the blended base amount for Iowa state-owned hospitals with over 500 beds to adjust for the high cost incurred for providing services to Medicaid patients. The State must provide assurances that the non-federal share of any high-cost adjustment payment is provided according to the relevant statutory and regulatory provisions and that providers retain 100% of the total claimed expenditure.
44. The State shall submit a revised version of SPA 03-017, which proposed new supplemental payments for physician services at publicly owned acute care teaching hospitals. The SPA proposed to pay qualifying physicians the difference between the base Medicaid rate and the provider's usual and customary charges. The revised version of SPA 03-017 will provide supplemental payments to qualifying physicians based upon the Medicare fee schedule or the average commercial rate. SPA 03-017 will be effective for the time period of July 1, 2003 through June 30, 2005.

The State must provide assurances that the non-federal share of any supplemental physician services payments is provided according to the relevant statutory and regulatory provisions and that providers retain 100% of the total claimed expenditure.

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45. As described in SPA's 04-007 and 03-017, the total Medicaid payments resulting from the Medicaid services provided to Medicaid enrollees are approximately \$59.7M. The Iowa State legislature will appropriate to the Iowa Medicaid agency an amount equal to the non-Federal share of the Medicaid payments made under SPA's 04-007 and 03-017 respectively. The total computable Medicaid payments related to these supplemental payments for the period that they are in effect shall not exceed \$54,639,129.
46. This demonstration proposes to provide monthly prospective interim payments to hospitals in the provider network serving Demonstration Populations 1 and 2, as well as to the providers rendering Demonstration Expansion Services 2. The State shall submit a new SPA effective July 1, 2005 fully describing this new payment methodology.
47. The University of Iowa Hospitals and Clinics (UIHC) was appropriated "State Papers" funding of \$27,284,584 for fiscal year 2005 and \$27,354,545 for fiscal year 2004, for a total of \$54,639,129. The funding was originally provided to the UIHC to pay for medical services to indigent persons served at the UIHC, who are not eligible for Medicaid coverage. The Iowa State Legislature will reauthorize these appropriations and will appropriate additional funds to both the Iowa State Medicaid agency as described above and the Health Care Transformation Account.
48. All future State Plan Amendments that will affect any of the Demonstration Populations must be submitted to CMS 30 days prior to execution. Any Amendment submitted after this date shall subject the State to deferred federal financial participation for Demonstration Population and service expenditures.
49. The State must submit by September 30, 2005 a revised inpatient hospital upper payment limit methodology, which is based on the acuity of services provided to Medicaid beneficiaries, effective for services beginning July 1, 2005.

#### **X. OPERATIONAL ISSUES**

50. Pursuant to Section II, paragraph 6, changes related to eligibility, enrollment, enrollee rights, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, Federal financial participation, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration, following the process set forth in Section II, paragraph 7. The state shall not implement changes to these elements without prior approval by CMS. CMS and the State shall develop a comprehensive list that shall contain all elements of the Demonstration that are subject to the amendment process within 60 days of the approval of the Demonstration.
51. Within 60 days of the approval of the Demonstration, the State shall develop a detailed "Implementation Plan" that will provide specific, measurable goals and the milestones, time lines, cost estimates, and responsible parties for the achievement of the goals outlined in HF 841. Recognizing that this Demonstration is only one component of a larger Medicaid transformation project, the State shall provide plans and regular updates

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on all facets of the transformation project, including timeframes and benchmarks.

52. Upon approval by CMS, the Implementation Plan shall serve as the guiding document for the programmatic aspects of the Medicaid transformation project, including this Demonstration, for the duration of the Demonstration. The Implementation Plan shall address:

- a) Activities undertaken to implement community based services to meet the needs of individuals in the Mental Health Transformation Pilot. This will result in moving the State toward Federal match funding of a managed care program for the mentally ill with an emphasis on deinstitutionalization. The Federal expenditure matching limits in Section VIII, paragraph 40 may not apply based on annual updates to this section of the Plan.
- b) Plans for implementing continuum of care mechanisms for this Demonstration including marketing, enrollee education, and provider education.
- c) Description of the State's quality assurance monitoring plan. The plan should include, at a minimum, the following: Quality indicators to be employed to monitor service delivery under the Demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys; and fraud control provisions and monitoring.
- d) Implementation of the personal health improvement plans for the Expansion Population.
- e) Quality monitoring activities for services rendered to Seriously Emotionally Disabled Children.
- f) Access to care for the Expansion Population, including possible provider network expansions, including free clinics, Federally Qualified Health Centers, Rural Health Clinics, and small professional practices in areas with limited access to healthcare professionals.
- g) Operations of the Account for Health Care Transformation and the IowaCare account.
- h) Actions taken by the State to implement its State Vision Statement for Long-Term Care" including establishing a universal assessment program for long-term care services.
- i) Plans and timeframes for developing and implementing a case mix adjusted reimbursement system for both institutional based and community based services for persons with mental retardation or developmental disabilities.
- j) Plans and timeframes for expanding alternatives for community-based care for individuals who would otherwise require care in an intermediate care facility for persons with mental retardation.
- k) Plans and timeframes for the design and successful implementation of a dietary counseling program by July 1, 2006.
- l) Identification of Quality Control mechanisms, indicators and reports for each phase of implementation including how variations from expected norms are incorporated into plans for improvement.

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53. The following performance benchmarks shall be reflected in the Implementation Plan:

- a) By October 1, 2006, the State shall develop a practical strategy for expanding utilization of electronic medical recordkeeping by providers under the medical assistance program and the expansion population provider network.
- b) By January 1, 2007, the State shall design and implement a provider incentive payment program for providers under the medical assistance program and providers included in the expansion population provider network based upon evaluation of public and private sector models
- c) By July 1, 2007, the State shall implement a program with the goal of reducing smoking among recipients of medical assistance who are children to less than one percent and among recipients of medical assistance and expansion population members those who are adults to less than ten percent,
- d) By July 1, 2008, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive care identified in the oral health standards under the early and periodic screening, diagnostic, and treatment program
- e) Provide to CMS by March 1, 2006 a copy of the Indigent Care Task Force's preliminary report of its efforts and findings.
- f) Provide to CMS by December 31 each year a copy of the Indigent Care Task Force's annual report.
- g) By July 1, 2006, the State shall submit to CMS a report of the results of an evaluation of the performance of each component of the Iowa Medicaid enterprise using the performance standards contained in the contracts with the Iowa Medicaid enterprise partners.
- h) Report at least annually to CMS on the activities of the Medical Assistance Projections and Assessment Council.
- i) Report at least annually to CMS the results of the study conducted by the State on barriers to private insurance for Iowans and possible impacts on this Demonstration project.

54. Substantial changes to the Implementation Plan shall be submitted to CMS for approval at least thirty days prior to the implementation of the change.

## **XI. EVALUATION**

55. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target populations for the Demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify

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whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.

- 56. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State shall implement the evaluation design, and submit to CMS a draft of the evaluation report 120 days prior to the expiration of the Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final report prior to the expiration date of the Demonstration.
- 57. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration.



# STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES  
KEVIN W. CONCANNON, DIRECTOR

June 21, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2279-P  
P.O. Box 8016  
Baltimore, MD. 21244-8016

Re: May 23, 2007 CMS Proposed Rule (File Code CMS-2279-P)  
Medicaid Program Graduate Medical Education Program Expenditures

To Whom It May Concern:

Following are comments by the Iowa Department of Human Services, Iowa Medicaid Enterprise, regarding the proposed rule that the Centers for Medicare and Medicaid Services (CMS) issued on May 23, 2007. The proposed rule provides clarification that costs and payments associated with Graduate Medical Education (GME) programs are not expenditures for medical assistance and are not federally reimbursable under the Medicaid program.

This is a significant change in policy and, considering its magnitude, statute changes would be more appropriate, rather than rule changes. To suddenly argue that GME payments are not in compliance with the statute is highly questionable, considering that the program has been in operation for 40 years.

Our technical-related concerns are described as follows:

*Direct Graduate Medical Education (GME) Costs.* The CMS commentary of the proposed rule acknowledges two types of cost/payments that are unique to teaching hospitals – direct graduate medical education and indirect medical education. The proposed rule defines direct GME as the direct costs of the educational activities, as measured by the number of residents being trained and the historic cost of training residents. When evaluating this definition in the context of the Medicare cost report (CMS 2552-96), it is unclear if the direct GME costs to be disallowed are all the direct costs of salaries and benefits for interns and residents (the post-step down adjustment found in column 26 of Worksheet B Pt I), or the Medicare allowed direct GME cost as calculated on Worksheet E-3, Pt. IV of the Medicare cost report. It is also not clear if other hospital overhead costs; such as administrative, capital, and maintenance, allocated to the education program cost centers are included as direct medical education costs and therefore deemed as non-allowable costs.

*Graduate Medical Education Payments.* The proposed rule for § 447.201 (c) states “the plan must not include payments for graduate medical education...” However, CMS commentary for the proposed rule specifically allows states to recognize, as part of the inpatient hospital rate structure, indirect medical education cost. It is not clear if graduate medical education payments in the proposed rule for § 447.201 (c) refers only to direct medical education or if it also refers to

indirect medical education payments. CMS commentary for the proposed rule redefines GME to be only direct medical education since indirect medical education (IME) costs are no longer identified as education costs, but instead are now considered to be an additional cost of providing care at teaching hospitals generally due to the added cost of "learning by doing" treatment methods. However, we request clarification from CMS on the definition of allowable graduate medical education payments, and emphasize that only direct intern and resident costs should be defined as non-health care costs.

*Upper Payment Limit (UPL) Calculation.* The proposed rule for § 447.272, Inpatient services: Application of upper payment limits, states that "for purposes of the Medicaid upper payment limit calculation, direct medical education payments are not an allowable component of a Medicare payment and must be excluded from the calculation." As stated above the definition of direct GME costs is unclear. The determination of direct medical education costs to exclude from the UPL calculation could vary based upon whether a cost-based or prospective payment system UPL methodology is utilized. In the past, CMS has allowed states flexibility in their UPL calculations. It is unclear if states will continue to have the flexibility to use the most appropriate definition of direct GME costs based upon the methodology utilized, or whether the proposed rule is intended to limit this long-standing flexibility afforded to states.

*Effective Date of Rule.* The provisions of the rule must be implemented in the first full state fiscal year following the effective date of the subsequent final rule. Does the language "In the first full state fiscal year" mean any day during the state fiscal year or the first day of the state fiscal year? It is unclear when states must have all reimbursement methodologies in compliance with the new rule, and therefore when any needed state plan amendments must be submitted.

Finally, we have included additional comments on this proposed rule from Iowa's two largest public teaching hospitals, the University of Iowa Hospitals and Clinics and Broadlawn's Medical Center, as attachments to this letter. We endorse the views of these hospitals, as well.

Sincerely,

*Eugene I. Gessow* by PEB

Eugene I. Gessow  
Iowa Medicaid Director

EIG/peb

Attachments

## ATTACHMENT ONE – UNIVERSITY OF IOWA HOSPITALS AND CLINICS

**From:** Cyphert, Stacey [stacey-cyphert@uiowa.edu]  
**Sent:** Tuesday, June 05, 2007 4:13 PM  
**To:** Gessow, Eugene  
**Subject:** Comments on GME Regulation

The May 23, 2007 proposed rule regarding Medicaid and Graduate Medical Education [28930-28936] would be detrimental to teaching hospitals. An article that appeared in the May 25, 2007 on-line edition of the *Chronicle of Higher Education* (see below) does a good job of explaining the problems with this proposed rule as well as the financial impact on the University of Iowa Hospitals and Clinics.

In addition to the content of this article, it is worth noting that the University of Iowa Hospitals and Clinics is engaged in the training of a significant number of residents and fellows above our cap. This is done in recognition of the importance of local training for attracting new physicians to the state. Over 36% of Iowa's total physician population has completed a University of Iowa residency or fellowship. A change such as the one being proposed, which would minimally cost the University of Iowa Hospitals and Clinics \$3.9 million annually, could place the University of Iowa Hospitals and Clinics in a position of having to further subsidize residency and fellowship training or reducing our commitment to this practice and possibly negatively impacting Iowa's physician workforce unless replacement funding can be found. This replacement funding is unlikely to come from the private sector.

### Teaching Hospitals Could Lose \$1.8-Billion Under Proposed Medicaid Cuts

By KATHERINE MANGAN

Teaching hospitals and other medical-education programs could lose at least \$1.8-billion under regulatory changes proposed this week by the U.S. Department of Health and Human Services.

The department, which for 40 years has provided states with matching grants for graduate medical education through the Medicaid program, has proposed pulling the plug on those grants. That would save the federal government \$1.78-billion between 2008 and 2012, according to a notice published in Wednesday's Federal Register.

The cost to the nation's teaching hospitals could be much higher if states respond to the loss of federal matching money by cutting their own Medicaid contributions for graduate medical education, according to Lynne Davis Boyle, assistant vice president for government relations for the Association of American Medical Colleges.

She said the proposed change, combined with President Bush's proposal to cut indirect medical-education payments for teaching hospitals that treat Medicare patients, could cripple some medical-residency training programs and force some smaller ones to close.

"We feel that this combination is an assault on teaching hospitals," Ms. Davis Boyle said. "Given the impending physician shortage, this is the wrong time for the government to be cutting back on residency training programs."

The medical-colleges' association has called on medical schools to increase their enrollments 30 percent by 2015 to avert a physician shortage as baby boomers age and large numbers of physicians retire (*The Chronicle*, November 7, 2005, and January 12, 2007). Dozens of new medical schools are opening or are in the planning stages, but their graduates will need hospital-based medical-residency programs to complete their training, critics of the cuts point out.

The government's Medicare and Medicaid programs have historically promised a steady supply of money to help teaching hospitals educate medical residents and partially compensate them for the higher costs of treating sicker patients and offering expensive, specialized services like burn units and trauma centers. In addition, hospitals that train physicians are inherently less efficient: "It takes longer to care for patients in a team setting where learning is taking place," Ms. Davis Boyle said.

Although they are not required to, every state except Illinois, North Dakota, and Texas made payments in 2005 toward graduate medical education through their Medicaid programs, according to a 2006 study commissioned by the medical-colleges' association.

The notice in the Federal Register concludes the following: "We do not believe that it is consistent with the Medicaid statute" to pay for graduate-medical-education activities "either as a component of hospital services or separately." Such education "is not a health service that is included in the authorized coverage package." Nor is it "recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services," the notice says.

Ms. Davis Boyle said that argument is unconvincing. "The fact that the government is just now realizing those payments aren't in compliance with the standards is questionable, given the fact that, for 40 years, the Medicaid program has acknowledged those services and costs are reimbursable."

The association is supporting efforts by Sen. Richard J. Durbin, an Illinois Democrat, to require a one-year moratorium before the Centers for Medicare & Medicaid Services could put the cuts in place. He introduced language to that effect in the massive federal spending bill being debated this week.

The University of Iowa Hospitals and Clinics would probably lose \$3.9-million a year in federal money and potentially more if the state cuts its share, said Stacey T. Cyphert, the system's senior assistant director. The system trains about 500 medical residents and 199 fellows. "It would be a challenge for us to figure out how to make up that loss," which represents about 23 percent of its Medicaid support for graduate medical education, Mr. Cyphert said.

## ATTACHMENT TWO – BROADLAWN'S MEDICAL CENTER



1801 Hickman Road  
Des Moines, Iowa 50314-1597  
515.282.2200  
www.broadlawns.org

June 1, 2007

Mr. Eugene Gessow  
Director of Medicaid  
Iowa Department of Human Services  
Medicaid Building  
100 Army Post Road  
Des Moines, IA 50315

Dear Mr. Gessow:

On behalf of Broadlawns Medical Center, I want to take a moment to thank you for requesting Broadlawns Medical Center's input regarding the proposed rule about Graduate Medical Education (GME) funding for the Medicaid program. The following are some of our concerns regarding this proposed rule:

1. Scope of training and value of resident training to the patients: CMS is trying to take a strict limited interpretation on the intent and responsibility for GME payments to include only "medical cost payment." This ignores the value of services provided by the residents to the patients receiving the care. Numerous studies cite the high quality of care in teaching facilities, especially with the current level of training and practices they provide. Based on these reports and our patient care plans we know there is much value added to the patients' care.
2. There are already significant amounts of costs for these programs for which Broadlawns Medical Center does not receive reimbursement. A review of our FY 2006 data shows the total program support by Broadlawns was over \$2,600,000. This includes total costs less all payments including billings to patients for services and existing GME payments.
3. The value of these programs to the State of Iowa and the U.S. healthcare landscape cannot be overlooked. Physicians who received training at Broadlawns Medical Center currently practice in most of the 99 counties in Iowa and across the country. Without these programs, the likelihood of attracting providers especially in rural areas would be significantly impacted.
4. Whose responsibility is it to train tomorrow's healthcare providers? It seems illogical to assume that the full burden for the unrecovered costs should be borne solely by providers such as Broadlawns Medical Center. As noted earlier, there already exists a large unreimbursed cost for these programs which Broadlawns is assuming. As a county hospital, Broadlawns Medical Center receives significant (over 50%) of its funding from

Mr. Gessow  
Page 2 of 2  
June 1, 2007

county taxes. It is not fair and would be a real issue for the Polk County citizens if they were told they must assume full responsibility for the training of tomorrow's healthcare providers when in fact many will not practice medicine in Polk County.

5. The impact of the proposed payment elimination has been determined by the Iowa Hospital Association to have an impact of approximately \$900,000 to Broadlawns Medical Center. Given our mission to serve all patients without regard to ability to pay and the already significant portion of unreimbursed costs, a reduction such as that proposed here would have a major impact. With annual gross revenues of approximately \$100 million, Broadlawns Medical Center is lucky to have a net income of \$1 million or one percent (1%). Such a reduction would have a repercussion in reduced ability to meet capital and patient needs in the future. We believe such a cost cutting measure is ill-advised.


Finally, this proposed rule would potentially impede Broadlawns Medical Center as we rely on the Residency Program to assist with providing healthcare services to some of our most vulnerable citizens. If our funding was altered and we did not have the Residents, we would need to hire additional physicians to provide the same level of care that we are currently providing. Broadlawns Medical Center would have to evaluate our programs and services to ensure we could continue to provide the same level of services to the community.

The Broadlawns Medical Center Residency Program is key to Iowa's and the United States' economic development in rural communities. Eighty-four or 62.2 percent of these graduates continue to practice medicine in Iowa. One hundred two or 76 percent practice in Iowa or surrounding states.

Two-thirds of all the physicians that are trained at Broadlawns Medical Center stay in Iowa. Broadlawns Medical Center provides healthcare services to individuals whose medical conditions are acute and require intense levels of intervention. The nature of our patients provides a training ground that foster independence so when the physicians leave to practice in a rural community, they are able to manage the care of the community.

Please let me know if I may be of additional assistance.

Sincerely,

  
Mikki Stier, MSHA, FACHE  
Senior Vice President  
Government and External Relations

MS/blb

Bcc: Gene Gessow  
Jennifer Vermeer  
Patti Ernst-Becker  
Dennis Janssen  
Marty Swartz  
Amy Perry  
Jeffery Marston  
Lesley Beerends  
Stacey Cyphert, University of Iowa Hospitals and Clinics  
Miki Stier, Broadlawn's Medical Center

## Nadolsky, Sally

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**From:** Gookin, Donald  
**Sent:** Monday, August 28, 2006 2:53 PM  
**To:** Vermeer, Jennifer  
**Cc:** Nadolsky, Sally  
**Subject:** RE: Survey on Rehabilitation Services & School-Based Administration and Transportation Services-Response Requested

**From:** Gregorio Hunt [mailto:GHunt@aphsa.org]  
**Sent:** Thursday, August 24, 2006 10:25 AM  
**To:** Martha Roherty; Andrea Maresca  
**Cc:** Gregorio Hunt  
**Subject:** Survey on Rehabilitation Services & School-Based Administration and Transportation Services-Response Requested

*\* All NASMD Members blind copied for privacy protection purposes.*

Good Morning State Medicaid Directors:

In the Administration's FY 2007 budget proposal, there are proposed changes to current Medicaid policy that would be implemented administratively. These changes would create stricter reimbursement for rehabilitative services and proposed elimination of school-based administration and transportation. We are trying to ascertain how your state has been or would be impacted with the proposed changes to these particular services. **Please complete the survey by close of business on Thursday, August 31.** The link to access the survey is <http://www.surveymonkey.com/s.asp?u=209692448756>.

**1. Please provide the following information:**

**State**  
**Name**  
**Title**  
**E-mail**  
**Phone**

Iowa  
Don Gookin  
Policy Specialist  
dgookin@dhs.state.ia.us  
(515) 725-1141

The President's budget seeks to clarify, through regulation, which services may be claimed as Medicaid rehabilitation services. The U.S. Department of Health and Human Services estimates that this proposal would save the federal government \$225 million in FY 2007 and \$2.3 billion over the FY 2007-2011 period.

**2. Have you been audited for rehabilitation services?**

☒ Yes

☐ No

**3. If yes, when was the audit and what were the disallowances and penalties assessed?**

Iowa's Adult Rehabilitation Services program was audited for Federal Fiscal Year 2002. The final report was issued March 23, 2005. Of the \$10,563,635 in Federal funds that the State claimed for FFY 2002, \$6,244,154 was unallowable.

Iowa's Rehabilitation and Treatment Support Services (RTSS) program for children was audited for Federal Fiscal Year 2001. The final report was issued July 6, 2004. Of the \$7,956,706 in Federal funds that the State claimed for FFY 2001, \$2,536,187 was unallowable.

**4. Has your state experienced conflicts between providers who have authorized rehabilitation services and those that have rendered rehabilitation services?**

☐ Yes

☒ No

**5. If yes, please explain.**

**6. Did CMS specify whether there was a concern for adult rehabilitation services, child rehabilitation services, or both?**

☐ Adult services

☐ Child services

☒ Both

**7. Have you been instructed by CMS Regional Office/Center Office to make changes to the allowable rehabilitation services? If yes, please explain those changes.**

No. Both audits recommended strengthening policies and procedures to assure rehabilitative services were being delivered, but no specific services were identified as being non-rehabilitative. However, Iowa is redesigning its rehabilitation services program to better match federal requirements and guidelines.

**8. Which services has CMS deemed not to be rehabilitative services?**

See #7.

**9. If your state has made changes, what has been the financial impact of those changes on your state?**

This is not known at this time. Program changes will not be effective until November 1, 2006.

**10. Are you interested in participating in an all-state call to discuss a strategy regarding rehabilitation services?**

☒ Yes

☐ No

The President's budget would, through administrative action, prohibit federal reimbursement for Individuals with Disabilities Education Act (IDEA)-related school-based administration and transportation costs. According to HHS estimates, this proposal would save the federal government \$615 million in FY 2007 and \$3.645 billion over the FY 2007-2011 period.

**11. What is the estimated financial impact of the elimination of school-based administrative services for you state, in state dollars?**

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**12. What is the estimated financial impact of the elimination of school-based transportation services for you state, in state dollars?**

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4936,000 federal dollars

**13. Has your state been contacted by CMS Regional Office/Central Office regarding school-based administration and transportation services? If yes, please describe the nature of the communication.**

**14. Has your state been audited for Medicaid claims paid for services provided in a school setting?**

☐ Yes

☐ No

**15. What types of restrictions, if any, are placed on the services**

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**16. Are you interested in participating in an all-state call to discuss a strategy regarding school-based administration and transportation services?**

☐ Yes

☐ No

**78.11(4)** Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 79.1(5) "j."

**78.11(5)** In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.12(249A) Remedial services.** Payment will be made for remedial services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a psychological disorder, subject to the limitations in this rule.

**78.12(1) Covered services.** Medicaid covers the following remedial services:

a. Community psychiatric supportive treatment, which offers intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning when less intensive remedial services do not meet the member's needs.

(1) Interventions must focus on the member's remedial needs to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Interventions may assist the member in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills, and communication.

(3) Community psychiatric supportive treatment is covered only for Medicaid members who are aged 20 or under.

(4) Community psychiatric supportive treatment is not intended for members in congregate care.

(5) Community psychiatric supportive treatment is not intended to be provided in a group.

b. Crisis intervention to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

c. Health or behavior intervention, used to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and communication skills.

(2) The purpose of intervention shall be to minimize or eliminate psychological barriers to the member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(3) Health or behavior intervention is covered only for Medicaid members aged 20 or under.

d. Rehabilitation program, which consists of interventions to enhance a member's independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize the member's ability to live and participate in the community.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Rehabilitation program services are covered only for Medicaid members who are aged 18 or over.

e. Skills training and development, which consists of interventions to enhance independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize a member's ability to live and participate in the community.

(1) Interventions may include the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Skills training and development services are covered only for Medicaid members aged 18 or over.

**78.12(2) Excluded services.** Services that are habilitative in nature are not covered as remedial services. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

**78.12(3) Coverage requirements.** Medicaid covers remedial services only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder. For example, licensed practitioners of the healing arts include physicians (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Ph.D. or Psy.D.), independent social workers (LISW), marital and family therapists (LMFT), and mental health counselors (LMHC). For purposes of this rule, the licensed practitioner of the healing arts must be:

(1) Enrolled in the Iowa Plan pursuant to 441—Chapter 88, Division IV; and

(2) Qualified to provide clinical assessment services under the Iowa Plan pursuant to 441—Chapter 88, Division IV (Current Procedural Terminology code 90801).

b. The licensed practitioner of the healing arts has recommended the remedial services as part of a plan of treatment designed to treat the member's psychological disorder. Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

c. The remedial services provider has prepared a written remedial services implementation plan that has been approved by:

(1) The member or the member's parent or guardian; and

(2) The medical services unit of the Iowa Medicaid enterprise.

**78.12(4) Approval of plan.** The remedial services provider shall submit the treatment plan and the remedial services implementation plan to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. *Initial plan.* The IME medical services unit shall approve the provider's initial remedial services implementation plan if:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(3);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan, as required in rule 441—77.12(249A);

(5) The plan does not exceed six months' duration; and

(6) The plan requires that written progress notes be submitted no less often than every six weeks to the IME medical services unit.

*b. Subsequent plans.* The IME medical services unit may approve a subsequent remedial services implementation plan according to the conditions in paragraph "a" if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress.

*c. Quality review.* The IME medical services unit will establish a quality review process. Reviews will evaluate:

- (1) The time elapsed from referral to remedial plan development;
- (2) The continuity of treatment;
- (3) The affiliation of the licensed practitioner of the healing arts with the remedial services provider;
- (4) Gaps in service;
- (5) The results achieved; and
- (6) Member satisfaction.

**78.12(5) Medical necessity.** Nothing in this rule shall be deemed to exempt coverage of remedial services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

- a.* Consistent with the diagnosis and treatment of the member's condition;
- b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c.* The least costly type of service that can reasonably meet the medical needs of the member; and
- d.* In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding best practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2006 Iowa Acts, House File 2734, section 10, subsection 11.

**441—78.13(249A) Transportation to receive medical care.** Payment will be approved for transportation to receive services covered under the program, including transportation to obtain prescribed drugs, when all of the following conditions are met.

**78.13(1)** Transportation costs are reimbursable only when:

- a.* The source of the care is located outside the city limits of the community in which the member resides; or
- b.* The member resides in a rural area and must travel to a city to receive necessary care.

**78.13(2)** Transportation costs are reimbursable only when:

- a.* The type of care is not available in the community in which the member resides; or
- b.* The member has been referred by the attending physician to a specialist in another community.

**78.13(3)** Transportation costs are reimbursable only when there is no resource available to the member through which necessary transportation might be secured free of charge. **EXCEPTION:** Costs of transportation to obtain prescribed drugs may be reimbursed irrespective of whether free delivery is offered when the prescription drug is needed immediately.

**78.13(4)** Transportation is reimbursable only to the nearest institution or practitioner having appropriate facilities for the care of the member.

**78.13(5)** Transportation may be of any type and may be provided from any source.

- a.* Effective November 1, 2005, when transportation is by car, the maximum payment that may be made will be the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of 30 cents per mile.

## 1915(i) HCBS State Plan Services

### Administration and Operation

1. **Program Title** (*optional*):

1915(i) HCBS State Plan Program

2. **State-wideness.** (*Select one*):

<input checked="" type="radio"/>	The State implements this supplemental benefit package statewide, per §1902(a)(1) of the Act.
<input type="radio"/>	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. ( <i>Check each that applies</i> ):
<input type="checkbox"/>	Geographic Limitation. HCBS state plan services will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. ( <i>Specify the areas to which this option applies</i> ):
<input type="checkbox"/>	Limited Implementation of Participant-Direction. HCBS state plan services will be implemented without regard to state-wideness requirements to allow for the limited implementation of participant-direction. Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. ( <i>Specify the areas of the State affected by this option</i> ):

3 **State Medicaid Agency (SMA) Line of Authority for Operating the HCBS State Plan Supplemental Benefit Package.** (*Select one*):

<input checked="" type="radio"/>	The HCBS state plan supplemental benefit package is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program ( <i>select one</i> ):
<input checked="" type="radio"/>	The Medical Assistance Unit ( <i>name of unit</i> ): Iowa Medicaid Enterprise
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit ( <i>name of division/unit</i> ):
<input type="radio"/>	The HCBS state plan supplemental benefit package is operated by ( <i>name of agency</i> ):
	a separate agency of the State that is not a division/unit of the Medicaid agency. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

**4. Distribution of State Plan HCBS Operational and Administrative Functions.**

☒ The State assures that in accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration or supervision of the state plan. When a function is performed by other than the Medicaid agency, the entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.

*(Check all agencies and/or entities that perform each function):*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Disseminate information concerning the state plan HCBS to potential enrollees	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 Assist individuals in state plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Manage state plan HCBS enrollment against approved limits, if any	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Review participant service plans to ensure that state plan HCBS requirements are met	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5 Recommend the prior authorization of state plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6 Conduct utilization management functions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7 Recruit providers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8 Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9 Conduct training and technical assistance concerning state plan HCBS requirements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10 Conduct quality monitoring of individual health and welfare and State plan HCBS program performance.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

*(Specify, as numbered above, the agencies/entities(other than the SMA) that perform each function):*

1. Information for potential enrollees may be disseminated by IME Policy staff, or by the Iowa Medicaid Enterprise's contractor for member services, Maximus Inc.
4. Service plan review is primarily done by the Iowa Medicaid Enterprise's contractor for medical services, the Iowa Foundation for Medical Care. This function may also be completed by the Iowa Medicaid Enterprise's Policy staff.
5. Recommendation for prior authorization is primarily done by the Iowa Medicaid Enterprise's contractor for medical services, the Iowa Foundation for Medical Care through the service plan review process. This function may also be completed by Iowa Medicaid Enterprise policy staff. Prior authorizations are done through the ISIS system, which enforces parameters such as unit and rate caps set by the Iowa Medicaid Enterprise.
6. Utilization management functions are set by Iowa Medicaid Enterprise policy staff and primarily carried out by the Iowa Medicaid Enterprise's contractor for medical services, the Iowa Foundation for Medical Care (IFMC). Needs-based eligibility criteria are determined by Iowa Medicaid Enterprise policy staff. IFMC reviews the needs-based evaluation to ensure the member meets the needs-based eligibility criteria. Parameters for prior authorization are determined by Iowa Medicaid Enterprise policy staff and are enforced through the ISIS system. IFMC reviews and authorizes service plan data in the ISIS system.
7. Recruitment of providers may be done by Iowa Medicaid Enterprise policy staff, or by the Iowa Medicaid Enterprise's contractor for provider services, Policy Studies Inc.
8. Execution of the provider agreement is primarily done by the Iowa Medicaid Enterprise's contractor for provider services, Policy Studies Inc. on behalf of the Iowa Medicaid Enterprise. The provider agreement has been written by Iowa Medicaid Enterprise staff in conjunction with the Iowa Attorney General's office.
9. Training and technical assistance is overseen by Iowa Medicaid Enterprise policy staff and primarily implemented by the Iowa Medicaid Enterprise's HCBS quality assurance and improvement contractor, Iowa State University. Iowa Medicaid Enterprise policy staff also conducts training as needed.
10. Quality monitoring is overseen by Iowa Medicaid Enterprise policy staff and primarily implemented by the Iowa Medicaid Enterprise's HCBS quality assurance and improvement contractor, Iowa State University.

5. ☒ **Conflict of Interest Standards.** The State assures it has written conflict of interest standards that, at a minimum, address the conduct of individual assessments and eligibility determinations.
6. ☒ **Appeals.** The State allows for appeals in accordance with 42 CFR 431 Subpart E.
7. ☒ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services.

## Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.** *(Specify):*

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/2007	12/31/2007	3700
Year 2	1/1/2008	12/31/2008	3885
Year 3	1/1/2009	12/31/2009	4079
Year 4	1/1/2010	12/31/2010	4283
Year 5	1/1/2011	12/31/2011	4497

2. **Optional Annual Limit on Number Served.** *(Select one):*

<input type="radio"/>	The State does not limit the number of individuals served during the Year.																								
<input checked="" type="radio"/>	The State chooses to limit the number of individuals served during the Year. <i>(Specify):</i>																								
	<table border="1"><thead><tr><th>Annual Period</th><th>From</th><th>To</th><th>Annual Maximum Number of Participants</th></tr></thead><tbody><tr><td>Year 1</td><td>1/1/2007</td><td>12/31/2007</td><td>3700</td></tr><tr><td>Year 2</td><td>1/1/2008</td><td>12/31/2008</td><td>3885</td></tr><tr><td>Year 3</td><td>1/1/2009</td><td>12/31/2009</td><td>4079</td></tr><tr><td>Year 4</td><td>1/1/2010</td><td>12/31/2010</td><td>4283</td></tr><tr><td>Year 5</td><td>1/1/2011</td><td>12/31/2011</td><td>4497</td></tr></tbody></table>	Annual Period	From	To	Annual Maximum Number of Participants	Year 1	1/1/2007	12/31/2007	3700	Year 2	1/1/2008	12/31/2008	3885	Year 3	1/1/2009	12/31/2009	4079	Year 4	1/1/2010	12/31/2010	4283	Year 5	1/1/2011	12/31/2011	4497
Annual Period	From	To	Annual Maximum Number of Participants																						
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Year 4	1/1/2010	12/31/2010	4283																						
Year 5	1/1/2011	12/31/2011	4497																						
<input type="checkbox"/>	The State chooses to further schedule limits within the above annual period(s). <i>(Specify):</i>																								

3. **Waiting List.** *(Select one):*

<input type="radio"/>	The State will not maintain a waiting list.
<input checked="" type="radio"/>	The State will maintain a single list for entrance to the HCBS state plan supplemental benefit package. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; ensure that otherwise eligible individuals have comparable access to all services offered in the package.

## Financial Eligibility

1. ☒ **Income Limits.** The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

2. **Medically Needy.** *(Select one):*

<input type="radio"/>	The State does not provide HCBS state plan services to the medically needy.
<input checked="" type="radio"/>	The State provides HCBS state plan services to the medically needy <i>(select one):</i>
<input type="radio"/>	The State elects to waive the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
<input checked="" type="radio"/>	The State does not elect to waive the requirements at section 1902(a)(10)(C)(i)(III).

## Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Independent evaluations/reevaluations to determine whether applicants are eligible for HCBS are performed (*select one*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other ( <i>specify</i> ): The Iowa Medicaid Enterprise Medical Services unit is responsible for annual approval. The Medical Services Unit is staffed through the Iowa Medicaid Enterprise's contract with the Iowa Foundation for Medical Care as noted in the above section titled "Distribution of State Plan HCBS Operational and Administrative Functions".

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** There are qualifications (that are reasonably related to performing evaluations) for persons responsible for evaluation/reevaluation for eligibility. (*Specify qualifications*):

The IME Medical Services unit requires that the individuals performing evaluations must be:

- a licensed practitioner of the healing arts –or–
- have a four-year health-related degree –or–
- be a registered nurse licensed in the State of Iowa with a minimum of 2 years experience providing relevant services

3. ☒ **Independence of Evaluators and Assessors.** The State assures that evaluators of eligibility for HCBS state plan services and assessors of the need for services are independent. They are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
  - financially responsible for the individual
  - empowered to make financial or health-related decisions on behalf of the individual
  - service providers, or individuals or corporations with financial relationships with any service provider.
4. **Needs-based HCBS Eligibility Criteria.** Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for HCBS state plan services. The criteria take into account the individual's support needs and capabilities and may take into account the individual's ability to perform two or more ADLs, the need for assistance, and other risk factors: (*Specify the needs-based criteria*):

The individual meets at least one of the following risk factors:

- Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently undergoing inpatient hospitalization demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan Services while in an institution, including hospitals.
- Has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

In addition, the person has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

- Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- Requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- Shows severe inability to establish or maintain a personal social support system.
- Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.
- Exhibits inappropriate social behavior that results in demand for intervention.

5. ☒ **Needs-based Institutional and Waiver Criteria.** There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of HCBS state plan services. Individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Include copies of the State's official documentation of the need-based criteria for each of the following):*

- *Applicable Hospital*
- *NF*
- *ICF/MR*

#### Differences Between Level of Care Criteria

State Plan HCBS Needs-based eligibility criteria	NF (& NF Level of Care Waivers)	ICF/MR (& ICF/MR Level of Care Waivers)	Applicable Hospital Level of Care (Psychiatric Hospital)
<p>The individual meets at least one of the following risk factors:</p> <ul style="list-style-type: none"> <li>• Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently undergoing inpatient</li> </ul>	<p>Based on the Minimum Data Set (MDS) section G, the individual requires supervision, or limited assistance provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living</p> <p>—OR—</p> <p>Based on the MDS, the individual requires the establishment of a safe,</p>	<p>1. A diagnosis of mental retardation before 18 years of age as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or a related condition as defined by the Code of Federal Regulations 41 CFR 35.1009.</p> <p>--AND--</p> <p>2. Three or more deficits resulting in substantial functional</p>	<p><b>Mental Status:</b></p> <p>A. Need for 24-hour professional observation, evaluation and/or diagnosis of a patient exhibiting behaviors consistent with acute psychiatric disorder, which may include significant mental status changes.</p> <p>B. Documented failure of current outpatient treatment including two or more of the following necessitating 24 hour professional observation supported by medical record documentation:</p> <ul style="list-style-type: none"> <li>o exacerbation of</li> </ul>

<p>hospitalization demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan Services while in an institution, including hospitals.</p> <p>› Has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.</p> <p>--AND--</p> <p>Has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:</p> <p>› Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.</p> <p>› Requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.</p> <p>› Shows severe inability to establish or maintain a personal social support system.</p> <p>› Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.</p> <p>› Exhibits inappropriate social behavior that results in demand for</p>	<p>secure environment due to modified independence (some difficulty in new situations only) or moderate impairment (decisions poor, cues and supervision required; never or rarely made a decision; danger to self or others) of cognitive skills for daily decision-making:</p> <ul style="list-style-type: none"> <li>○ Cognitive, Mood and behavior patterns</li> <li>○ Physical functioning-Mobility</li> <li>○ Skin condition</li> <li>○ Pulmonary Status</li> <li>○ Continence</li> <li>○ Dressing and Personal Hygiene (ADL's)</li> <li>○ Nutrition</li> <li>○ Medications</li> <li>○ Communication</li> <li>○ Psycho-social</li> </ul>	<p>limitation in major life activity areas as defined in 42 CFR 435.1009(d):</p> <ul style="list-style-type: none"> <li>○ Self-care</li> <li>○ Understanding and use of language</li> <li>○ Learning</li> <li>○ Mobility</li> <li>○ Self Direction</li> <li>○ Capacity for independent living</li> </ul>	<p>symptoms</p> <ul style="list-style-type: none"> <li>○ noncompliance with medication regimen</li> <li>○ lack of therapeutic response to medication</li> <li>○ acute neuroleptic reaction</li> <li>○ psychotropic or neuroleptic medication toxicity</li> <li>○ lack of patient participation in the outpatient treatment program</li> </ul> <p>Information regarding prior hospitalizations and length of stay will be obtained as well as evaluation of the patient's medical stability to participate in a comprehensive treatment plan.</p>
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State: Iowa  
TN: MS-07-001  
Effective:

§1915(i) HCBS State Plan Services

State Plan Attachment 3.1 – C:

Page 8

Approved:

Supersedes: None

intervention.			
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6. ☒ **Reevaluation Schedule.** The State assures that needs-based reevaluations are conducted at least annually.
7. ☒ **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

## Person-Centered Planning & Service Delivery

1. ☒ The State assures that there is an independent assessment of individuals determined to be eligible for HCBS. The assessment is based on:
  - An objective face-to-face evaluation by a trained independent agent;
  - Consultation with the individual and others as appropriate;
  - An examination of the individual's relevant history, medical records, care and support needs, and preferences;
  - Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in § 7702B(c)(2)(B) of the Internal Revenue Code of 1986); and
  - Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct.
2. ☒ The State assures that, based on the independent assessment, the individualized plan of care:
  - Is developed by a person-centered process in consultation with the individual, the individual's: treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
  - Identifies the necessary HCBS to be furnished to the individual, (or, funded for the individual, if the individual elects to participant-direct the purchase of such services);
  - Takes into account the extent of, and need for, any family or other supports for the individual;
  - Prevents the provision of unnecessary or inappropriate care;
  - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
  - Is reviewed at least annually and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**  
There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. (*Specify qualifications*):

Educational/professional qualifications of individuals conducting assessments are as follows:

  1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services.

-Or-

  2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services.
4. **Responsibility for Service Plan Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. (*Specify qualifications*):

Individualized, person-centered plans of care will be developed by individuals with the following educational/professional qualifications:

1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services.

-Or-

2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services.

- 5. Supporting the Participant in Service Plan Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

(a) The service plan is developed by the participant and his or her interdisciplinary team based on information from the needs-based assessment, and taking into account the participant's social history, and treatment and service history. The case manager acts as an advocate for the participant in this process and is a source of information for the participant and the team. The participant and the team identify the participant's strengths, needs, preferences, desired outcomes, and his or her desires in order to determine the scope of services needed. The case manager informs the participant of all available Medicaid and non-Medicaid services. The participant is encouraged to choose goals based on his or her own desires while recognizing the need for supports to attain those goals.

(b) The interdisciplinary team includes the participant; his or her legal representative if applicable; the case manager; and any other persons the participant chooses, which may include service providers. Individuals that are not Medicaid providers are not reimbursed for their participation.

- 6. Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the service plan):*

The case manager informs the participant and his or her interdisciplinary team of all available qualified providers. This is part of the interdisciplinary team process when the service plan is developed, and again whenever it is renewed or revised. Participants are encouraged to meet with the available providers before choosing a provider.

**7. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the service plan is made subject to the approval of the Medicaid agency):*

The Iowa Department of Human Services has developed a computer system named the Individualized Services Information System (ISIS) to support certain Medicaid programs. This system assists with tracking information and monitoring the service plan and enforces parameters such as unit and rate caps set by the department. The case manager requests a payment slot through this system, and Iowa Medicaid Enterprise (IME) staff responsible for managing enrollment limits respond. Case managers complete the assessment of the need for services and submit it to the IME Medical Services unit for evaluation of program eligibility. The case manager is also responsible for entering service plan information such as the services to be received, the effective dates, the amount of each service, and the selected provider into ISIS, where it is reviewed for authorization by IME Medical Services staff.

**8. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other <i>(specify)</i> :				

## Services

**1. HCBS State Plan Services.** *(Complete the following table for each service. Copy table as needed):*

<b>Service Specifications</b> <i>(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):</i>			
Service Title:		<b>HCBS Case Management</b>	
Service Definition (Scope):			
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Individuals who receive Targeted Case Management under the Medicaid State plan cannot also receive case management under Section 1915(i). Participants are free to choose their provider from any enrolled provider of this service.			
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :			
Participants have a need for support and assistance in accessing services.			
Specify limits (if any) on the amount, duration, or scope of this service for <i>(choose each that applies)</i> :			
<input type="checkbox"/>	Categorically needy <i>(specify limits)</i> :		
<input type="checkbox"/>	Medically needy <i>(specify limits)</i> :		
Specify whether the service may be provided by a <i>(check each that applies)</i> :		<input type="checkbox"/>	Relative
		<input type="checkbox"/>	Legal Guardian
		<input type="checkbox"/>	Legally Responsible Person
<b>Provider Qualifications</b> <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify)</i> :	License <i>(Specify)</i> :	Certification <i>(Specify)</i> :	Other Standard <i>(Specify)</i> :
Case Management Provider		Providers must be certified under Iowa Administrative Code 441-24, which includes meeting the following qualifications: 1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services. -Or- 2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services.	
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Case Management Provider	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification (either 270 days, 1 year, or 3 years)
<b>Service Delivery Method.</b> (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> (Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):	
Service Title:	<b>Habilitation</b>
Service Definition (Scope):	
<p>Services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.</p> <p>Components of this service include the following:</p> <p><b>1. Home-based Habilitation</b> means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community.</p> <p>These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision. Home-based habilitation is not covered for participants residing in a residential care facility of more than 16 persons. Services provided in a licensed residential care facility of 16 or fewer persons will be considered to take place in the participant's home when the participant's service plan documents that the participant resides there by their own choice, and is provided with opportunities for independence and community integration. Participants are free to choose their provider from any enrolled provider of this service. The service plan will include a discharge plan and documentation of any rights restrictions. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.</p> <p><b>2. Day Habilitation</b> means assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or as specified in the participant's service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. Participants are free to choose their provider from any enrolled provider of this service.</p> <p><b>3. Prevocational Habilitation</b> means services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized</p>	

result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Participants are free to choose their provider from any enrolled provider of this service. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

**4. Supported Employment Habilitation** means services that consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations which do not include those for which providers are already responsible to make in order to meet requirements of the Americans with Disabilities Act, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

Participants are free to choose their provider from any enrolled provider of this service.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Participants have a need for supports to assist in the acquisition, retention, or improvement in skills related to living in the community. Additionally, for the prevocational habilitation and supported employment habilitation components, individuals have a need for ongoing supports to prepare for, obtain, or maintain employment.

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

☒ Categorically needy (*specify limits*):

For the supported employment component, a unit of service for "activities to obtain a job" is one job placement. A unit of service for "supports to maintain employment" is an hour with a maximum of 40 units per week.

For all other components, a unit of service is hourly, half-day or a day. There is an upper limit for these services per hour, per half-day, or per day.

All limits are subject to change each year. All components of habilitation being utilized must be authorized in the participant's service plan. The case manager will monitor the service plan.

☒ Medically needy (*specify limits*):

<p>For the supported employment component, a unit of service for “activities to obtain a job” is one job placement. A unit of service for “supports to maintain employment” is an hour with a maximum of 40 units per week.</p> <p>For all other components, a unit of service is hourly, half-day or a day. There is an upper limit for these services per hour, per half-day, or per day.</p> <p>All limits are subject to change each year. All components of habilitation being utilized must be authorized in the participant’s service plan. The case manager will monitor the service plan.</p>			
Specify whether the service may be provided by a		<input type="checkbox"/>	Relative
(check each that applies):		<input type="checkbox"/>	Legal Guardian
		<input type="checkbox"/>	Legally Responsible Person
<b>Provider Qualifications</b> (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Home-based habilitation providers		<p>Meet any of the following:</p> <ul style="list-style-type: none"> <li>Accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF)</li> <li>Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</li> <li>Accredited by the Council on Accreditation (COA)</li> <li>Accredited by the Council on Quality and Leadership (CQL)</li> <li>Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Supported Community Living for the HCBS MR Waiver under 441-IAC 77.37(1) through 77.37(14) or the HCBS BI Waiver under 441-IAC 77.39(1) through 77.39(10) and 77.39(13).</li> <li>Certified by the department as a provider of Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.4(12).</li> </ul>	
Day habilitation providers		<p>Meet any of the following:</p> <ul style="list-style-type: none"> <li>Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)</li> <li>Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</li> <li>Accredited by the Council on Quality and Leadership (CQL)</li> <li>Accredited by the International Center for Clubhouse Development (ICCD)</li> <li>Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Day Habilitation for the HCBS MR Waiver under 441</li> </ul>	

		<p>IAC 77.37(13) and 77.37(27).</p> <ul style="list-style-type: none"> <li>• Certified by the department as a provider of Day Treatment under 441-IAC 24.2 through 24.4(8) and 24.4(10) or Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.4(12).</li> </ul>	
Prevocational habilitation providers		<p>Meet any of the following:</p> <ul style="list-style-type: none"> <li>• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)</li> <li>• Accredited by the Council on Quality and Leadership (CQL)</li> <li>• Accredited by the International Center for Clubhouse Development (ICCD)</li> <li>• Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Prevocational services for the HCBS MR Waiver under 441 IAC 77.37(13) and 77.37(26) or the HCBS BI Waiver under 441-IAC 77.39(22).</li> </ul>	
Supported employment habilitation providers		<p>Meet any of the following:</p> <ul style="list-style-type: none"> <li>• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)</li> <li>• Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</li> <li>• Accredited by the Council on Accreditation (COA)</li> <li>• Accredited by the Council on Quality and Leadership (CQL)</li> <li>• Accredited by the International Center for Clubhouse Development (ICCD)</li> <li>• Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Supported Employment for the HCBS MR Waiver under 441 IAC 77.37(1) through 77.37(13) and 77.37(16) or the HCBS BI Waiver under 441-IAC 77.39(1) through 77.39 (10) and 77.39(15).</li> </ul>	
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Home-based habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	<p>Verified at initial certification and thereafter based on the length of the certification:</p> <ul style="list-style-type: none"> <li>○ either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers or certified</li> </ul>	

		under IAC 441-24 <ul style="list-style-type: none"> <li>○ either 1 year or 3 years when accredited by CARF; either 3 years or 4 years when accredited by COA;</li> <li>○ 3 years when accredited by JCAHO</li> <li>○ 4 years when accredited by CQL</li> </ul>
Day habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: <ul style="list-style-type: none"> <li>○ either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR Waiver or certified under IAC 441-24</li> <li>○ either 1 year or 3 years when accredited by CARF or ICCD</li> <li>○ 3 years when accredited by JCAHO</li> <li>○ 4 years when accredited by CQL</li> </ul>
Prevocational habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: <ul style="list-style-type: none"> <li>○ either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers</li> <li>○ either 1 year or 3 years when accredited by CARF or ICCD</li> <li>○ 4 years when accredited by CQL</li> </ul>
Supported employment habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: <ul style="list-style-type: none"> <li>○ either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers</li> <li>○ either 1 year or 3 years when accredited by CARF or ICCD</li> <li>○ either 3 years or 4 years when accredited by COA</li> <li>○ 3 years when accredited by JCAHO</li> <li>○ 4 years when accredited by CQL</li> </ul>
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

**2. Policies Concerning Payment for State Plan HCBS Furnished by Legally Responsible Individuals, Other Relatives and Legal Guardians. (Select one):**

<input checked="checked" type="radio"/>	The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan HCBS.
<input type="radio"/>	The State makes payment to <i>(check each that applies)</i> :
<input type="checkbox"/>	<b>Legally Responsible Individuals.</b> The State makes payment to legally responsible individuals under specific circumstances and only when the relative is qualified to furnish services. <i>(Specify (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) in cases where legally responsible individuals are permitted to furnish personal care or similar services, the State must assure and describe its policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual); (c) how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the State's strategies for ongoing monitoring of the provision of services by legally responsible individuals; and, (e) the controls that are employed to ensure that payments are made only for services rendered):</i>
<input type="checkbox"/>	<b>Relatives.</b> The State makes payment to relatives under specific circumstances and only when the relative is qualified to furnish services. <i>(Specify: (a) the types of relatives who may be paid to furnish such services, and the services they may provide, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by relatives, and; (d) the controls that are employed to ensure that payments are made only for services rendered):</i>
<input type="checkbox"/>	<b>Legal Guardians.</b> The State makes payment to legal guardians under specific circumstances and only when the guardian is qualified to furnish services. <i>(Specify: (a) the types of services for which payment may be made, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by legal guardians, and; (d) the controls that are employed to ensure that payments are made only for services rendered):</i>
<input type="checkbox"/>	<b>Other policy. (Specify):</b>

## Participant-Direction of Services

*Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).*

**1. Election of Participant-Direction.** (Select one):

<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of state plan HCBS.
<input type="radio"/>	Every participant in HCBS state plan services (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in HCBS state plan services (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. (Specify criteria):

**2. Description of Participant-Direction.** (Provide an overview of the opportunities for participant-direction under the HCBS State Plan option, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

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**3. Participant-Directed Services.** (Indicate the HCBS that may be participant-directed and the authority offered for each. Add lines as required):

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**4. Financial Management.** (Select one):

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as an administrative function.

**5. ☐ Participant-Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

6. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

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7. **Opportunities for Participant-Direction**

- a. **Participant–Employer Authority** (individual can hire and supervise staff). *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	<b>Participant/Co-Employer.</b> The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	<b>Participant/Common Law Employer.</b> The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- b. **Participant–Budget Authority** (individual directs a budget). *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	<b>Participant-Directed Budget.</b> <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):</i>
	<b>Expenditure Safeguards.</b> <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):</i>

## Quality Management Strategy

*(Describe the State's quality management strategy in the table below):*

<b>Requirement</b>	<b>Monitoring Activity (What)</b>	<b>Monitoring Responsibilities (Who)</b>	<b>Evidence (Data Elements)</b>	<b>Management Reports (Yes/No)</b>	<b>Frequency (Mos/Yrs)</b>
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1. Review of plans after they are developed.  2. Quality Assurance review process	1. Service worker supervisor or case management supervisor.  2. DHS quality assurance staff	1. Service plan checklist in file  2. Consumer interview.	Yes.	1. All plans at least every 12 months  2. Continuous; by random sample of 200 providers per year.
Providers meet required qualifications	1. Annual compliance review  2. File and organization outcomes review	1. IME provider services unit  2. DHS quality assurance staff	1. Documentation of certification  2. required certification or licensure	No.	1. Sample of 200 HCBS providers per year  2. All providers once every three years
The SMA retains authority and responsibility for program operations and oversight.	1. Program oversight by DHS's Iowa Medicaid Enterprise.  2. DHS bureau of long-term care contracts with Iowa State University for quality assurance.	1. Program policy specialist  2. DHS monitors contract with Iowa State University.	1. State plan, administrative rules, provider manuals.  2. Quality assurance plan; activity tracking.	1. Yes.  2. Yes.	1. Continuous.  2. Contract with Iowa State University is monitored quarterly.
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	1. ISIS system assures claims are paid within authorized limits for each individual.  2. Billing audits	1. IME data warehouse and CORE units.  2. DHS Bureau of purchased services.	1. Authorization data.  2. MMIS claims history, ISIS authorization	1. Yes.  2. Yes.	1. Continuous.  2. Continuous.

			data, and provider files.		
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Service plans address health and welfare and contain individualized emergency plans.  2. Incident reporting to DHS.  3. Abuse and neglect reports.	1. Case managers.  2. Providers (with compliance checks by DHS QA staff).  3. DHS Child and Adult Protective Bureau	1. Service plans.  2. Incident reports  3. Abuse and neglect reports.	1. No.  2. Yes.  3. Yes.	1. All plans at least every 12 months  2. All incident reports; continuously.  3. All abuse or neglect reports; continuously.
Describe the process(es) for remediation and systems improvement.	<p><b>Overall System</b>            The QA/QI system, at a minimum, addresses:</p> <ul style="list-style-type: none"> <li>• Health and safety issues of consumers receiving HCBS services</li> <li>• Abuse/neglect/exploitation of consumers</li> <li>• Consumer access to services</li> <li>• Plan of Care discrepancies</li> <li>• Availability of services</li> <li>• Complaints of service delivery</li> <li>• Training of providers, case managers, and other stakeholders</li> <li>• Emergency procedures</li> <li>• Provider qualifications</li> <li>• Consumer choice</li> </ul> <p>The QA/QI system shall continuously collect data for use in improving quality of services. Data shall come from a variety of sources including HCBS provider databases, site reviews, follow-up compliance reviews, complaint investigations, evaluation reports, consumer satisfaction surveys, consumer interviews, and consumer records.</p> <p>Data from all QA/QI activities is compiled by the HCBS QA Specialists and presented to the HCBS QA/QI committee on a quarterly basis. The QA/QI committee analyzes the data to determine patterns, trends, problems, and issues in service delivery of HCBS services. Based on this analysis, recommendations for changes in policy are made to the IME Policy staff and Bureau Chief. The committee also uses this information to direct HCBS Specialists to provide training, technical assistance, or other activity. The committee monitors training and technical assistance activities to assure consistent implementation statewide. The QA/QI committee is made up of certain HCBS Quality Assurance staff and supervisors (who function under the Iowa State University contract),</p>				

and DHS Policy staff. Minutes are taken at each of the meetings, which show evidence that analysis of data is completed and recommendations for remediation and system improvement are made

#### **Service Plans**

All consumers have a consumer centered, outcome based service plan of care developed by the interdisciplinary team to address all assessed needs and health and safety risk factors of consumer as well as personal goals. Services plans will address both met and unmet needs of the consumer. Service plans are updated and revised annually or as a consumer's needs change. The consumer is informed of their right to change their plan at anytime and they acknowledge this by signing a service plan checklist. The Case Manager will monitor the service plan on a monthly basis to assure that services are delivered in the type, scope, amount, duration and frequency are delivered in accordance with the plan. All service plans are reviewed by the local supervisor of case managers for approval after they are developed. On an annual basis, IME will randomly select 200 HCBS providers for Quality Assurance review. The 200 providers shall be selected based on length of time the provider has been an HCBS provider, starting with the providers with the longest HCBS history selected first. The selection of providers will continue with another 200 provider selected until all providers have been reviewed. The QA review process includes desk reviews of provider records and on-site reviews. On-site reviews include a review of records and documentation of services, staff interviews, and consumer interviews. During the QA review process, service plans are monitored to assure that assessed needs are being identified in the service plan and are updated and revised as needed. If systematic inadequacies in service plan development are found through the QA process, training packets are sent out, regional trainings are held, and a report is made to the QA/QI committee which may recommend further action as described above under "overall system".

During the service plan development, consumers are presented with an option of available providers in their area and are given a choice on what provider they want to use. In addition a service plan checklist is used by case manager that identifies that the consumer was presented with choice. The consumer and the case manger sign off on the checklist and it becomes part of the consumer's file. The case manager incorporates and approves the chosen provider into the service plan. As a follow up, during the QA interview process, consumers are asked if they had a choice of providers and also review files for documentation.

#### **Qualified Providers**

On an Annual basis, IME provider services will randomly select 200 HCBS providers, both licensed and non-licensed, to review eligibility criteria. Information will be requested from the provider that documents current compliance with eligibility criteria for each program and each service that the provider is certified/enrolled to provide as listed on the ISIS system. The 200 providers shall be selected based on length of time the provider has been an HCBS provider, starting with the providers with the longest HCBS history selected first. The selection of providers will continue with another 200 provider selected until all providers have been reviewed. The cycle

will start over when all providers have been reviewed. A series of letters shall be sent to each provider requesting that the provider submit information stating how the provider meets eligibility criteria for each HCBS service they are certified/enrolled to provide. If providers do not respond to these requests within the timeframes identified in the letter, termination in the Medicaid program will occur. The Department of Human Services, Bureau of Purchased Services does random audits of providers to ensure that they meet state and federal requirements. Through the QA process, DHS currently does a random sampling of providers to review files and organizational outcomes. DHS is in the process of implementing a quality assurance process that will review all provider agencies in the state once in a three-year period. This file review will include a discover process to ensure that training and education is provided based on the certification or licensure needed for each provider. After each review, the HCBS specialist identifies if any deficiencies exist and work individually with the provider to develop a corrective action plan. In addition, if systemic deficiencies are found with providers, HCBS specialists will provide training in the regional quarterly meetings.

#### **SMA Authority**

DHS sets policy and provides oversight over the program. The Bureau of Long Term Care contracts with Iowa State University to provide quality assurance activities. Iowa State University is the only entity that the SMA currently delegates quality assurance activities to. There is a contract that specifies the exact functions that Iowa State University is to carry out for the SMA. The contract was awarded through a competitive bidding process. Performance measures are included in the contract and are monitored quarterly by SMA policy staff.

DHS is responsible for the following Contractor internal quality assurance functions:

1. Consult with the contractor on quality improvement measures and determination of areas to be reviewed.
2. Monitor the contractor's performance of all contractor responsibilities.
3. Review and approve proposed corrective action(s) taken by the contractor.
4. Monitor corrective actions taken by the contractor.

Iowa State staff are responsible for the following quality assurance functions, all of which are monitored at least quarterly by DHS policy staff:

1. Work with DHS to implement a quality plan that is based on proactive improvements rather than retroactive responses.
2. Develop and submit to DHS for approval, a Quality Assurance Plan establishing quality assurance procedures.
3. Designate a quality assurance coordinator who is responsible for monitoring the accuracy of the contractor's work and providing liaison between the contractor and DHS regarding contractor performance.
4. Submit quarterly reports of the quality assurance coordinator's activities, findings and corrective actions to DHS.

5. Provide quality control and assurance reports, accessible online by DHS and Contractor management staff, including tracking and reporting of quality control activities and tracking of corrective action plans.
6. For any performance falling below a state-specified level, explain the problems and identify the corrective action to improve the rating.
7. Implement a state-approved corrective action plan within the time frame negotiated with the state.
8. Provide documentation to DHS demonstrating that the corrective action is complete and meets state requirements.
9. Perform continuous workflow analysis to improve performance of Contractor functions and report the results of the analysis to DHS.
10. Provide DHS with a description of any changes to the workflow for approval prior to implementation.

#### **Financial Accountability**

The Iowa Department of Human Services has developed a computer program, named the “Individualized Services Information System” or “ISIS,” that will support the program. The purpose of ISIS is to assist workers in these programs in processing and tracking requests, starting with an initial entry from the ABC system through approval or denial. Upon approval, participants will use ISIS to provide the Iowa Medicaid Enterprise with information and authority to make payments to or on behalf of a consumer. The consumer is tracked in ISIS until that consumer is no longer accessing the program. There are certain points in the ISIS process that will require contact with designated DHS central office personnel and other outside entities. These contacts must be made in order for the ISIS process to proceed. These contacts may include the HCBS program manager, contacts for HCBS slots assignment and waiting lists, the Iowa Medicaid Enterprise medical services unit. A case normally starts with an income maintenance (IM) worker entering information into the Department’s Automated Benefit Calculation (ABC) system. The ABC system passes pertinent information about the case to ISIS. Then ISIS identifies a key task (called a “milestone”) for the IM worker who entered the original data into ABC. This key task is the first in a series of milestones for actions by service workers, case managers, central point of coordination administrators, and many others. These milestones form a workflow taking a request for a facility or HCBS program to denial or final approval.

In addition, the Department of Human Services Bureau of Purchased Services performs both financial and performance audits of Medicaid Providers. The billing audit is to ensure:

1. HCBS providers appropriately and accurately document the provision of services so that claims paid by the Department are eligible for reimbursement.
2. To limit the risk of providers having to refund payments to the Department because they have submitted ineligible claims.
2. To limit the risk of the Department losing or having to return matching federal funds because of having paid ineligible claims.

At the end of each state fiscal year, an analysis of payments, recoupments and other risk related factors will be used to select and prioritize providers for billing audits to be conducted during the next auditing year (from October 1 to September 30).

**Abuse, Neglect, and Exploitation**

All service plans must address health and welfare of consumers. All service plans must address a back up plan for situations when service providers are not available and also an emergency plan.

Providers are required to report both major and minor incidents to the state. Major incidents are to be reported within 72 hours. Providers are required to submit a report on minor incidents annually that includes any action steps that were taken to resolve incidents. The state monitors, tracks and trends all major incidents, abuse and neglect reports and complaints. For major incidents, if it appears that a consumer could be placed in eminent jeopardy, the HCBS specialist will respond immediately. For all other incident reports, the HCBS specialist will respond within 48 hours. The Child and Adult Protective Bureau within the Department of Human Services is responsible for informing the HCBS specialist of abuse and neglect reports. The HCBS specialist follows up to ensure an incident report was filed. A log is maintained that tracks the reports the follow-up that has been completed. During the QA interview process, consumers are asked if they know how to report abuse and provider files are reviewed to ensure incidents were reported.

All required incident reports are sent to the IME and entered into a database. The Quality Assurance Committee reviews incident data quarterly to make policy changes and/or arrange for provider trainings. Recommendations for changes in policy are made to the IME Policy staff and Bureau Chief. The committee also uses this information to direct HCBS Specialists to provide training, technical assistance, or other activity. The committee monitors training and technical assistance activities to assure consistent implementation statewide.

## Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input checked="" type="checkbox"/>	HCBS Case Management
	<p>Reimbursement is based on a fee schedule that sets fees for each provider based on their approved rate as a Targeted Case Management provider. Providers of case management services are reimbursed on the basis of a payment for a month's provision of service for each participant enrolled for any portion of the month based on reasonable and proper costs for service provision. The monthly unit includes all case management services utilized for the participant during the entire month. For both providers and the state Medicaid agency, billing on a monthly basis is more economical than using 15-minute increments because the amount of bookkeeping is drastically reduced. Providers must still document all billable activity and rates are initially set using time studies that track activities in 15-minute increments. All providers are reimbursed at actual cost, so reducing the amount of bookkeeping required by providers results in lower indirect costs. For each fiscal year, a projected monthly rate is established for each participating provider, based on reasonable and proper costs of operation pursuant to federally accepted reimbursement principles (Medicare or OMB A-87 principles) and based on submission of actual costs of operation for the preceding year reported by the provider on financial and statistical reports. Case management services will not be subject to cost settlement. The methodology for determining the reasonable and proper cost for service provision assumes the following:</p> <p>(1) The indirect administrative costs shall be limited to 20 percent of other costs.</p> <p>(2) Mileage shall be reimbursed at a rate no greater than the state employee rate.</p> <p>(3) The rates a provider may charge are subject to limits established at Iowa Administrative Code 441-79.1(2).</p>
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Basic Homemaker
<input type="checkbox"/>	HCBS Chore Services
<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input type="checkbox"/>	HCBS Personal Care I
<input type="checkbox"/>	HCBS Personal Care II
<input type="checkbox"/>	HCBS Attendant Services
<input type="checkbox"/>	HCBS Adult Companion
<input type="checkbox"/>	HCBS Personal Emergency Response Systems

State: Iowa  
TN: MS-07-001  
Effective:

§1915(i) HCBS State Plan Services

State Plan Attachment 4.19–B:

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Approved:

Supersedes: None

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	<input type="checkbox"/>	HCBS Assistive Technology
<input type="checkbox"/>		HCBS Adult Day Health

<input checked="" type="checkbox"/>	Habilitation
<input checked="" type="checkbox"/>	<p data-bbox="370 310 760 352">HCBS Home-Based Habilitation</p> <p data-bbox="370 352 1435 688">Reimbursement is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.</p>
<input checked="" type="checkbox"/>	<p data-bbox="370 688 656 730">HCBS Day Habilitation</p> <p data-bbox="370 730 1435 1066">Reimbursement is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.</p>
<input type="checkbox"/>	<p data-bbox="370 1066 734 1108">HCBS Behavioral Habilitation</p>
<input type="checkbox"/>	<p data-bbox="370 1129 704 1171">HCBS Educational Services</p>
<input checked="" type="checkbox"/>	<p data-bbox="370 1203 766 1245">HCBS Prevocational Habilitation</p> <p data-bbox="370 1245 1435 1581">Reimbursement is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.</p>
<input checked="" type="checkbox"/>	<p data-bbox="370 1581 883 1608">HCBS Supported Employment Habilitation</p>

		Reimbursement for Supported Employment is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.
<input type="checkbox"/>	Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services	
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation	
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)	

2. **Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) (*Select one*):

<input checked="" type="radio"/>	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
<input type="radio"/>	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be <input type="text"/> days (not to exceed 60 days).